IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TEXARKANA DIVISION

THE STATE OF TEXAS, Plaintiff	)	
VS.	)	CIVIL ACTION NO. 5-96CV91
THE AMERICAN TOBACCO COMPANY, ET AL	)	

ORAL DEPOSITION
OF
PHILIP HUANG, M.D., VOLUME I

(ACCOMPANIES VIDEOTAPE)

SEPTEMBER 10, 1997

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THE STATE OF TEXAS, Plaintiff	)	
VS.	)	CIVIL ACTION NO. 5-96CV91
THE AMERICAN TOBACCO COMPANY; R.J. REYNOLDS TOBACCO COMPANY; BROWN & WILLIAMSON TOBACCO CORPORATION; B.A.T. INDUSTRIES, P.L.C.; PHILIP MORRIS, INC.; LIGGETT GROUP, INC.; LORILLARD TOBACCO COMPANY, INC.; UNITED STATES TOBACCO COMPANY; HILL & KNOWLTON, INC.; THE COUNCIL FOR TOBACCO RESEARCH-USA, INC. (Successor to Tobacco Institute Research Committee); AND THE TOBACCO INSTITUTE, INC., Defendants	)	

* *

ORAL DEPOSITION OF PHILIP HUANG, M.D.

* *

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ANSWERS AND DEPOSITION OF PHILIP HUANG, M.D., a witness called by the DEFENDANT PHILIP MORRIS, taken before SALLY KING, Certified Court Reporter for the State of Texas, on SEPTEMBER 10, 1997, beginning at 9:39 a.m. and ending at 3:55 p.m., at the offices of the Attorney General of the State of Texas, 300 West 15th Street, Second Floor, Austin, Texas 78701, pursuant to the Federal Rules of Civil Procedure.

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PHILIP HUANG, M.D.

was called as a witness and, having been first duly sworn, testified as follows:

EXAMINATION

BY MR. HLAVINKA:

THE VIDEOGRAPHER: 9:39 a.m. 09:39

Q. Will you state your name, please, sir, for the record? 09:40

A. Philip Huang. 09:40

Q. Dr. Huang, my name is Victor Hlavinka, like I said while ago, and I'm here to ask you some questions about your opinions in this case. What is your current occupation? 09:40

A. I am the chief of the Bureau of Chronic Disease Prevention and Control at the Texas Department of Health. 09:40

Q. I was unable to get a good notion of your -- of the consecutive employments that you've had over your lifetime from your resume. Could I ask you about those things? I understand that you went to Rice for undergrad school, right? 09:40

A. Right. 09:40

Q. And you had a degree in civil engineering? 09:40

A. Yes. 09:40

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Q. And then did you go right straight to medical school? 09:40

A. Yes, I did. 09:40

Q. Southwestern, was it? 09:40

A. Yes. 09:40

Q. All right. And when did you finish there? 09:40

A. 1986. 09:40

Q. What residency training did you have after you finished your M.D.? 09:40

A. Family practice. 09:40

Q. And where did you take that? 09:40

A. Here in Austin at -- it was Central Texas Medical Foundation. 09:41

Q. Did you have any outside employment during that time? 09:41

A. I did some moonlighting at some minor emergency rooms. 09:41

Q. And was that -- at that time was that a three or four-year residency? 09:41

A. Three-year residency. 09:41

Q. And so you finished that in '89, did you? 09:41

A. Yes. 09:41

Q. And following that completion, what did you undertake by way of work or other occupation? 09:41

A. I received -- pursued my master in public 09:41

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health at Harvard. 09:41
Q. And how long a program is that in terms -- 09:41
A. It was a one-year program. 09:41
Q. You went directly, then, from South -- from Austin to Boston, or Cambridge? 09:41
A. Yes. 09:41
Q. All right. And did you have any outside employments during that time? 09:41
A. I did again some moonlighting at some minor emergency rooms. 09:41
Q. Then as of 1990, when you finished that program, what occupation did you undertake? 09:41
A. I went to work with the Centers for Disease Control and Prevention as an epidemic intelligence service officer. I was assigned to the State of Illinois. 09:42
Q. What kind of work did you do in that particular job? 09:42
A. It was a field epidemiology position, so doing epidemiology, both some chronic disease epidemiology as well as some infectious disease epidemiology. 09:42
Q. Did you do work in actual collection of data, or simply data analysis working on data collected by others? 09:42

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A. I did some work in data collection and some work in analysis of data collected by others. 09:42
Q. Was there any disease or were there any diseases that you focused on in your studies? 09:42
A. As I mentioned, I did a mixture of some chronic disease issues as well as infectious disease issues. I did an investigation of a cyclo -- what turned out to be cyclospora outbreak in Chicago. At the time we did not know it was cyclospora, and I did some tobacco-related research, some cancer investigations. 09:42 09:43 09:43 09:43 09:43 09:43 09:43
Q. Was the tobacco-related research specifically with regard to some -- some cancer entity? 09:43 09:43
A. Actually, one of the projects that I worked on was -- is in one of the articles -- was published in one of the articles that I believe you have, working with looking at cigarette advertising and youth. 09:43 09:43 09:43 09:43 09:43
Q. All right. So it had more to do with the marketing of tobacco then with the health effects of tobacco. Is that fair? 09:43 09:43 09:43
A. That was -- that particular study, yes. 09:43
Q. And you said that you focused upon some certain chronic diseases and certain 09:44 09:44

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infectious diseases. Which chronic diseases were involved in this? 09:44

A. There were again numerous diseases that worked with neuroblastoma, retinopathy of prematurity, again some cancer cluster investigations. That's what comes to mind immediately, and there were some other issues. 09:44

Q. I suppose -- okay. I suppose that the infectious diseases involved HIV. Is that what you were looking at, or something else? 09:44

A. I did one project working on HIV, and again I mentioned cyclospora was one issue I worked on. Again, there was -- I did one TB investigation. 09:44

Q. All right. And all of that was focused in Illinois, I take it? 09:45

A. Yes. 09:45

Q. Was your entire career with the CDC one that you spent with an Illinois focus? 09:45

A. Oh, actually, I guess let me go back on that. 09:45

Q. Sure, sure. 09:45

A. I did do some work actually working with the, I guess at the time it was called Alcohol, Drug Abuse and Mental Health Administration 09:45

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on assignment working on a special project, and so I would not say that everything was focused solely on Illinois. 09:45

Q. What was the nature of your special project with the alcohol and drug abuse business? 09:45

A. We were looking at different models for surveillance and assessment of drug treatment needs. 09:46

Q. What was the factor, if there was any one factor or if there were identifiable factors, that motivated you to undertake your work in the business of tobacco marketing that you alluded to awhile ago? 09:46

A. I think that -- I mean, I recognize certainly being in public health that tobacco use is one of the most -- is the leading preventable cause of death and disease in our country. I was interested in -- I mean, I think that there are -- I had learned certainly through my training of the problems with youth initiation of smoking and was made aware of some resources in Illinois at the University of Illinois, Chicago, some people who I could work with that had experience and that I could collaborate with on some projects -- on 09:47

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a project to look at. 09:47
Q. Did someone direct you to that project, or did you undertake it of your own volition? 09:47
A. I would say that there was an opportunity that arose, again because of some of the expertise that was in the state. I had made it clear to the people I was working with that I wanted a broad experience during my period with CDC and again was made aware of some resources in the state at the University of Illinois, Chicago, and was able to collaborate with them on some -- 09:47
Q. All right. How long did you stay with the CDC? 09:48
A. I was with CDC for two years. 09:48
Q. Did you have any assignment during that time that took you to Texas? 09:48
A. I don't recall any -- no, there was -- I do not recall any specific assignment that directly involved that. 09:48
Q. Are you a native of Houston? 09:48
A. I grew up in Dallas. 09:48
Q. In Dallas. What's your age, by the way? 09:48
A. 36. 09:48
Q. And so you must have completed your CDC work 09:48

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sometime in 1992; is that correct? 09:48
A. That's correct. 09:48
Q. And what occupation did you pursue following that? 09:48
A. As I mentioned, I took the current position that I have as chief of the Bureau of Chronic Disease at the Texas Department of Health. 09:48
Q. What are your job responsibilities in your current position? 09:49
A. I oversee several areas that are dealing with chronic disease prevention and control. 09:49
Q. In your oversight responsibilities, what do you do on a day-to-day basis? 09:49
A. Well, part of the responsibilities include collecting data for the State regarding chronic disease. That's the assessment sort of component, evaluating some of that data, translating it into or identifying problem areas and issues that we will deal with in terms of chronic disease prevention, dealing with programmatic areas and policy implications, things like that. 09:49
Q. Does the data that you collect or that's collected under your auspices, does it relate strictly to disease prevalence, or does it 09:50

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also involve demographic information and things such as that? 09:50

A. Could you repeat that, please? 09:50

Q. I said, the data that's collected by your organization, is it confined to data regarding disease prevalence, or does it go into demographics and other characteristics of the population? 09:50

A. We have -- some broad data collection activities that we have, includes cancer incidents, which our -- many of the data sets include much demographic information. We have behavioral risk factor information, we have programmatic information that's collected, various -- we look at vital statistics, many data sources that we look at. 09:50

Q. How does your organization relate to the Bureau of Vital Statistics? 09:51

A. We -- the Bureau of Vital Statistics is in the Texas Department of Health. 09:51

Q. Okay. 09:51

A. We use the data in many of the things that we do, analyze the data, work with them very close. 09:51

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Q. Can you easily itemize the various categories of data that the Bureau of Vital Statistics collects, or is that a much too broad a thing to tackle off the top of your head? 09:51
A. I'm sorry. Could you repeat the question? 09:51
Q. I said, can you easily itemize the particular categories of data that the Bureau of Vital Statistics collects, or is that too broad a question to tackle? 09:51
A. What do you mean by itemize? 09:51
Q. Yes. List the various things that the Bureau collects. 09:51
A. I can list -- certainly, I'm aware that they collect death certificate data, birth certificate data. Those are the two that I primarily work most with them on. 09:52
Q. You are a licensed physician, are you? 09:52
A. Yes, I am. 09:52
Q. And what states are you licensed in? 09:52
A. I have an active license in Texas. 09:52
Q. Do you practice medicine? 09:52
A. I do one clinic afternoon a week, yes. 09:52
Q. How much time do you actually devote to that each week? 09:52
A. Approximately one-half day per week. Some 09:52

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weeks wind up not going because of other conflicts. 09:52

Q. Is that clinic here in Austin? 09:52

A. Yes, it is. 09:52

Q. And does it have a focus as far as whether or not it deals with pediatric patients or general family type patients or some particular other category of patients? 09:52 09:53 09:53 09:53

A. The particular clinic that I'm currently working is a family planning clinic. 09:53 09:53

Q. Are you a member of any organizations who have an expressed agenda -- an expressed anti-smoking agenda, and if so, what are they? 09:53 09:53 09:53 09:53

A. I would not characterize anything as anti-smoking. I would say that I certainly belong to many organizations that are interested in improving health. 09:53 09:53 09:53 09:53

Q. None with a principal focus of anti-tobacco or anti-smoking? 09:53 09:53

A. Again, I would say that any of the organizations that I belong probably focused on improving the health. 09:53 09:53 09:53

Q. Give me a listing of the organizations of which you are a member. 09:53 09:54

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A. Actually, could I even -- could I refer to -- 09:54

MR. THOMPSON: Do you have a copy 09:54

of his CV to help him or -- 09:54

MR. HLAVINKA: All I received was 09:54

this -- this narrative. I don't have a CV 09:54

myself.

MR. THOMPSON: Why don't we mark

it and let him -- give him a copy of this.

MR. HLAVINKA: Yeah. If you have a 09:54

CV, that would be great. We can mark that 09:54

and attach it to the deposition and we'll 09:54

save a lot of time. 09:54

MR. THOMPSON: Yeah. I'll make you 09:54

a copy, because it was provided at the time. 09:54

I guess -- do you want to take a break?

MR. HLAVINKA: No. You want this 09:54

one back? 09:54

MR. THOMPSON: Why don't you mark 09:54

it as an exhibit. Let me make sure it's not 09:54

attached to something. In fact, this has got 09:54

the transmittal letter. 09:54

MR. HLAVINKA: My folks just didn't

get it to me.

MR. THOMPSON: That's okay.

THE WITNESS: There may be other 09:54

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organizations that I contribute to or -- that would not be -- that are not listed. I did not -- 09:55 09:55

MR. HLAVINKA: Exactly. 09:55

MR. THOMPSON: Why don't we -- there's no question, and so why don't we go ahead and mark that, please, so the doctor can see it.

(Deposition Exhibit No. 1 09:55
(marked for identification.

Q. In your current position, Doctor, are you pursuing any special research projects, or is your assignment more broad and general than that? 09:55 09:55 09:55 09:55

A. Currently I am involved in several areas of chronic disease prevention and control. 09:55 09:55

Q. Can you itemize those for us as far as you can remember them? 09:55 09:55

A. In terms of my direct -- well, again, itemize. 09:55 09:56

Q. List them. 09:56

A. And are you saying -- asking what areas are in my bureau? 09:56 09:56

Q. No, you -- what areas that you are now researching, specifically researching. 09:56 09:56

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A. In terms of research projects? 09:56
Q. Yes, sir. 09:56
A. I mean, I have several activities going on. 09:56
I don't know that I would say because -- that 09:56
I am particularly working on any research 09:56
project. Much of my current work, day-to-day 09:56
work, does involve oversight and 09:56
administration of many of these programmatic 09:56
areas related to chronic disease. My -- 09:56
Q. And those projects would include epidemiology 09:56
studies, I take it? 09:56
A. We have some ongoing projects that are always 09:57
sort of being worked on or being looked at, 09:57
certainly. 09:57
Q. Well, is there some grouping of -- of health 09:57
data that the bureau routinely collects and 09:57
has been collecting for some time, and if so, 09:57
what type of information do you collect 09:57
regarding what disease entities? 09:57
A. The Cancer Registry is one of the areas of my 09:57
bureau, and that collects cancer incidence 09:57
data for the state. The Behavioral Risk 09:57
Factor Surveillance System is another ongoing 09:57
surveillance activity which is in my bureau. 09:57
Q. I understand that the BRFSS does not collect 09:58

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information regarding whether or not the studied population is involved in the Medicaid program; is that correct? 09:58

A. That is not correct. As of 1996, a question was added in terms of insurance status. 09:58

Q. So up until '96 there was no Medicaid information collected, and since that time there has been? 09:58

A. Yes. In 19 -- actually, okay. In 19 -- let me rephrase it. 09:58

Q. Sure. 09:58

A. In 1996 a question was added to the core survey that asked about insurance status, including Medicaid. 09:58

Q. And was that question asked during 1996, or was it asked in the subsequent year '97? 09:59

A. Oh. The question has been asked in '96 and is also included on the '97 questioning. 09:59

Q. Is the '96 questioning result along those lines, is that available in any published document, and if so, what document would that be found in? 09:59

A. We have not published that data. The '96 data we've finally gotten processed and we actually did a very recent run of that and I 09:59

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believe that's in the materials that you have that were provided to you. 09:59
Q. The stuff from your file? 09:59
A. Yes. 09:59
MR. THOMPSON: And I think there's a printout that was previously provided that is -- that provides that data. 09:59
Q. Do you have any teaching positions, Doctor? 09:59
A. I do have a position with the School of Public Health. 09:59
Q. Here at U.T.? 09:59
A. Yes, in Houston. 10:00
Q. In Houston. And what is your situation there? How long have you been involved there on the faculty and do you have actual classroom teaching responsibilities or what do you do? 10:00
A. I guess the title is adjunct assistant professor of disease control since 1995, and I have taught one class session there. 10:00
Q. Specifically in what -- in what subject matter? 10:00
A. It was chronic disease activities. 10:00
Q. In your -- 10:00
A. And I believe focusing on some of the 10:00

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epidemiology.
Q. In your work at the Harvard School of Public Health, did you have courses in epidemiology?
A. Yes, I did.
Q. And how much -- how many course hours did you take in that particular study?
A. I don't remember.
Q. You don't remember?
A. I don't remember the exact number of course hours, no, I don't.
Q. Do you remember how many semesters you matriculated in that area?
A. I can't tell you exactly. I would have to review that.
Q. Now, you have -- you've been named here in this case as an expert witness for the State. Do you understand that?
A. Yes, I do.
Q. When were you first advised that you would be called upon to give expert testimony in this case?
A. I believe it was three months ago, something along those lines.
Q. And who was it that made the contact with you?

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A. I believe it was Harriet Cheney. Harriet Cheney. 10:01
Q. And was that -- that contact made in person or by telephone? 10:02
A. By telephone. 10:02
Q. Did you subsequently meet with anyone, whether it's Ms. Cheney or someone else, regarding your involvement here as an expert witness? 10:02
A. Yes. 10:02
Q. With whom? 10:02
A. I met with Jeff Thompson and Hugh McNeely and Harry Potter, and David Alvarado was present. 10:02
Q. When Ms. Cheney contacted you, what information did she give you regarding what she expected from you or would like to ask of you and what your assignment might be? 10:02
A. As I recall, it was -- I mean, when Ms. Cheney first spoke to me, it was regarding some of the epidemiologic data regarding tobacco and some of the Texas information. 10:03
Q. Did you provide any information to her in response to that first telephone contact? 10:03
And then I'll ask you another question which 10:03

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you might answer the same time, if you can. 10:03
That is, did you in response -- did she at 10:03
that time send you any information for you to 10:03
review? 10:03
A. As far as I recall, I do not remember sending 10:03
anything or receiving anything after that 10:03
contact, no. 10:03
Q. How long was it before you then met with 10:03
either Mr. Thompson or anybody else that 10:03
you've named here, McNeely or Potter or 10:03
Alvarado? 10:03
A. Regarding the deposition? 10:03
Q. Regarding your involvement here as an expert 10:04
witness, yes, whether it was in preparation 10:04
for deposition or otherwise. 10:04
A. I believe it was a few months. A few months. 10:04
Q. Okay. At some point in the time since your 10:04
initial contact from Ms. Cheney, have you 10:04
been provided any compilation of documents or 10:04
other information sources? 10:04
A. Can you clarify that? 10:04
Q. Sure. Have they given you any papers to look 10:04
at? 10:04
A. I would say I was asked more to pull together 10:04
papers, I think the material that you 10:04

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received. I'm trying to think. I know that there are some documents that they have mentioned that I might look at. I really haven't looked at -- looked at them. They mentioned that I might be looking at that at some point in the future or be asked to do that. 10:05

Q. Have they given you copies of those documents or simply mentioned them to you or described them to you? 10:05

A. I have not -- I do not possess any copies of the documents. 10:05

Q. All right. 10:05

A. Actually, last night I was given a copy of one monograph that was hard to get or something. 10:05

Q. All right. Can you -- is that monograph in this stack of papers here? 10:05

A. Yes, I believe so. 10:05

Q. We may as well talk about this at this point. Before we began this morning, I was handed a -- two separate pieces of -- or stacks of documents, one that seems to be a copy of an article. 10:05 10:06 10:06

MR. THOMPSON: Just for the record, 10:06

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what you've got, there are several articles there. 10:06

MR. HLAVINKA: Okay. 10:06

MR. THOMPSON: And some of which I think may have already been provided, but there was some question in my mind, so I had a second copy made. 10:06

MR. HLAVINKA: Good. 10:06

MR. THOMPSON: And then the other pile are some additional documents that we located in Mr. Huang's file that had not been previously copied, I think, so I went ahead and copied them for you. And thirdly, there is the color photographs which I told you we would provide today. 10:06

MR. HLAVINKA: Yes, those are across there. 10:06

Q. I've been handed a pile that I'm now holding in my right hand, and before we go into the specifics of what's in this pile, do you recognize this as a group of documents that came from your file? 10:06

A. Yes, I do recognize those. 10:06

Q. And were these documents collected specifically by you for the purposes of this 10:07

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lawsuit? 10:07
A. Yes. I would say I was -- as I was reviewing, I thought that those might be helpful. 10:07
Q. Okay. And were all of these collected by you? That is, did you gather them yourself? 10:07
A. Either myself or some of the staff at the health department. 10:07
Q. You asked them to get them for you? 10:07
A. Right. Pull together a few articles, yes. 10:07
Q. I really at this point don't want to take the time to go through them. I'd like to have the batch marked as one -- one exhibit for the time being, and then I'll ask someone else to look at them as we go along and maybe we can save some time. 10:07

MR. HLAVINKA: Can you mark this first batch as our Exhibit No. 2?

(Deposition Exhibit No. 2 10:08
(marked for identification.

MR. HLAVINKA: All right. So the batch that's been enclosed in a large black clip is Exhibit No. 2, and I'll ask the reporter to mark the batch that's enclosed in a smaller black clip as Exhibit No. 3. 10:08

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(Deposition Exhibit No. 3 10:08
(marked for identification.
Q. Can you tell us for the record what Exhibit 10:08
No. 3 is comprised of? 10:09
A. Could I take a look? 10:09
Q. Sure. 10:09
A. Just a collection of some articles that might 10:09
be relevant. 10:09
Q. And where do these articles arise from? That 10:09
is, how did they get here this morning? 10:09
A. I provided -- I gave them to Mr. Thompson and 10:09
they were copied, I think. 10:09
Q. So these are articles that you sought out and 10:09
collected and then provided to counsel and 10:09
not vice versa? 10:09
A. Yes. 10:09
Q. Okay. Thank you. Let me have those and I'll 10:09
hand them back to Mike. 10:09
Do you have any other documentation 10:09
in your file, that is the file that you 10:10
maintain in connection with your work on this 10:10
case? 10:10
A. I believe that other stack (indicating) had 10:10
some other things that weren't just journal 10:10
articles that were some -- 10:10

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Q. Yes. 10:10
A. -- some -- again I mentioned some updated data runs that we tried to do and things like that. 10:10
Q. Just a quick glance through there indicated to me that there's some statistical data in tabular form, stuff like that in there, among other things; is that correct? 10:10
A. Yes, yes. 10:10
Q. Now, but aside from Exhibits Nos. 2 and 3 in the context of those two exhibits, are there other documents in the file that you collected and put together for this case that is not here with us this morning? 10:10
MR. THOMPSON: Well, I'm not -- I don't mean to -- are you asking other than what we've provided as part of the disclosure and the additional materials we provided this morning? 10:10
MR. HLAVINKA: Yeah. I'm asking about what's in his file. I think that he told me that while he had some items mentioned to him, he didn't have them in his possession; is that correct? 10:11
MR. THOMPSON: No, they're here. 10:11

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Q. Okay. So you have other materials with you? 10:11
A. I believe you -- I believe there's some materials here, uh-huh. 10:11
Q. And what are they? 10:11
MR. THOMPSON: Do you want him to go through his box or -- 10:11
Q. I want to know what they are. Do you know what they are? 10:11
A. I -- my understanding is that some of those are some internal tobacco industry documents. 10:11
Q. Have you had an opportunity to look at those documents? 10:11
A. No, I haven't. 10:11
MR. HLAVINKA: Okay. Now, Jeff, I understand that these things are the items that you say were listed as -- listed in the attachment to his report; is that correct? 10:11
MR. THOMPSON: Let's be specific, because I'm not sure when you say "these items" what you're asking about. 10:12
MR. HLAVINKA: The items in the box. 10:12
MR. THOMPSON: For the record, with his disclosure there were -- there were documents provided, copies that were out of 10:12

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his personal file, number one. Number two, there was a listing of two things: Publicly available documents which we didn't copy for you, like vital statistics and things like that; and secondly, a list of documents produced in discovery by defendants. I think you're talking about the final category, and the answer is, they are here in a box and they are the same as the copies I provided to you at your office earlier this week. 10:12

MR. HLAVINKA: Excellent. Regarding that first category that you described -- and you certainly aren't being questioned here, but I wondered if you might tell me -- 10:12

MR. THOMPSON: That's fine. 10:12

MR. HLAVINKA: -- was that sent to Stoever, or who was that sent to? 10:12

MR. THOMPSON: Yes. And if we want to go off the record real quick, I will help you. If you've got -- if you want me to show you what I've sent, I'll be happy to. 10:12 10:13 10:13

MR. HLAVINKA: Yeah.

MR. THOMPSON: Why don't we go off the record. 10:13

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MR. HLAVINKA: Sure.
THE VIDEOGRAPHER: Going off the record at 10:12 a.m. 10:13
(RECESS) 10:19
THE VIDEOGRAPHER: Back on the record at 10:30 a.m. 10:30
(Deposition Exhibit No. 4 (marked for identification. 10:31
Q. Doctor, I've placed before you an item that's been identified as Exhibit No. 4, and I'll ask you to tell us whether or not you recognize any portion of that document, and if so, what portions do you recognize? 10:31
A. Yes, I recognize all of this. 10:31
Q. All right. Let's look -- it does include, does it not, a corrected version of your report? And I've done some underlining on there that is not your responsibility. But now, Doctor, the first -- strike that. 10:31 10:32
Let me reach across here and look at it for just a second. I believe this is Page 1, but it's not numbered as such because the page just after it is marked Number 2. That page includes a listing of items, does it not? 10:32

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A. Yes, there's a list of items on this page. 10:32
Q. And it's headed by the statement that those are publicly available reliance documents; is that correct? 10:32
A. Yes. 10:32
MR. HLAVINKA: And for the record, Tom, you're telling me that those items are the things that you have in the box here that we haven't even looked at. 10:32
MR. THOMPSON: Yes, sir. 10:32
MR. HLAVINKA: All right. 10:32
MR. THOMPSON: And there are two additional items that are -- the originals of which are in here that weren't on the list. 10:33
MR. HLAVINKA: Okay. 10:33
MR. THOMPSON: You want to identify them for the record? 10:33
MR. HLAVINKA: Yeah, let's identify them. Sure. The box also contains a book called Growing Up Tobacco Free published by the National Academy Press and a monograph called Preventing Tobacco Use Among Young People, a Report of the Surgeon General published by the U.S. Department of Health and Human Services. 10:33

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MR. THOMPSON: And those were resources that the doctor asked me to add to that list. 10:33

Q. Now, the items that are listed there on Page 1 before you, have you actually reviewed those documents? 10:33

A. I am -- I cannot say that I have read every single document cover to cover. I'm generally familiar with these documents -- I mean, yes, I have seen the documents. 10:34

Q. I'm sure that from your past work you are familiar with those documents or with most of them, but in connection with your work on this case, have you specifically -- have you read any of those documents? 10:34

A. I would say again I have looked at and reviewed and referenced certainly many of these documents. I cannot say that I have read cover to cover these documents. 10:34

Q. Sure. Can you identify any of them here now for us that you did for sure read and review in your work on this case? 10:34

A. Again, can you clarify that? 10:34

Q. Yeah. Can you specify by the numbers that they're identified with there on the 10:34

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left-hand margin, can you specify any of those that you know for sure that you did read in connection with your work on this case? 10:34 10:34 10:35 10:35

A. And are you saying as a reference or looked at maybe a page or a chart or something in one of these? 10:35 10:35 10:35

Q. Okay. If there are any that you read completely, will you please itemize those first and then we'll talk about the others. 10:35 10:35 10:35

A. Okay. I can tell you I probably have not read any of these completely in preparation for this case. 10:35 10:35 10:35

Q. All right. Then are there -- are there others where you did refer to specific portions of them on an excerpted basis? 10:35 10:35 10:35

A. Yes. 10:35

Q. All right. Can you identify any of those for us? 10:35 10:35

A. I would say definitely the vital statistics report. 10:35 10:35

Q. Suppose you use the numbers there along the left-hand margin for us. 10:35 10:35

A. Okay. It's hard to say. Again, I think that there are probably charts or tables in many 10:35 10:35

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of these that might be referenced in other publications, so that I think they're all generally useful. So I'm just again trying to get a sense of what you're asking and why. 10:35 10:36 10:36 10:36

Q. Well, my interest is whether you have a recollection of actually looking at any portion of any of those items, and if so, which of the items did you actually look at, to your recollection. 10:36 10:36 10:36 10:36 10:36

A. I would say number one -- and again, you're asking for just this deposition or in my daily work? I mean, in the last -- 10:36 10:36 10:36

Q. For your work on this case, yes. 10:36

A. Okay. So in the last month or two if I had looked at this document, but it might have been as part of my work. 10:36 10:36 10:36

MR. THOMPSON: And let me clarify. I'm sorry. Maybe it will speed it along. The doctor is entitled to rely upon things that he uses in his everyday work that a reasonable person in his profession would rely upon, and those include the documents that are listed, whether or not he's recently read them or ever read them in detail. So if that helps. 10:36 10:36 10:36 10:37 10:37 10:37 10:37 10:37 10:37

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MR. HLAVINKA: I understand that.
MR. THOMPSON: They provide support for general opinions and also are referenced in a number of the articles that have been provided. 10:37
Q. Right. But my immediate interest is whether you actually did glean information from any of those documents in connection with your work on this case, and if so, can you identify the ones from which you did glean information. 10:37
A. Okay. Well, what comes to mind, I mean, I think Number 1, Number 16, some of Number -- actually, Number 7 was a new one that I was not familiar with that I glanced briefly at. 10:38
Q. Okay. 10:38
A. I think some of the other surgeon general reports are sort of referenced in Number 16. That's the ones that stand out. 10:38
Q. All right.
A. Maybe Number 3, but not really in particular. 10:38
Q. Okay. Let's look at -- let's look at Pages 2, 3 and 4, I think, of Exhibit Number 4 -- actually be Pages 2, 3, 4 and 5. 10:38
MR. THOMPSON: And 6. 10:38

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MR. HLAVINKA: And 6. That's a listing of documents that I'm told -- and, Jeff, tell me if I'm wrong -- that are included in the stack that I have here and that you've given to me. 10:38 10:38 10:38 10:39 10:39

MR. THOMPSON: Correct. 10:39

Q. All right. And without belaboring the point, can you recall specifically whether or not you have -- whether you made specific reference to any of those documents in your work or in your preparations for serving as an expert in this case? 10:39 10:39 10:39 10:39 10:39 10:39 10:39

A. I might have -- I mean, saw Jeff looking at something, a couple of these. I don't -- I'm not even sure which ones they were. 10:39 10:39 10:39

Q. That's fair. And before I forget, I had occasion to briefly look at some materials that I understand have been provided to Mr. Stoever with the defense's interest in this case that are now stacked on the table here before us. I glanced at them during our recess, and I ran across this item here from the stack nearest to you which is headed "Content of Texas BRFSS Questionnaire." And do you recognize this item? 10:39 10:39 10:39 10:39 10:39 10:39 10:39 10:39 10:39 10:40 10:40 10:40 10:40

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A. Yes, I do. 10:40
Q. Okay. And tell me what it is. 10:40
A. This is -- we have tried to summarize all the questions over time that were -- have been asked on the Texas Behavioral Risk Factor Surveillance System and to then put a check mark by what years those specific questions were asked. 10:40
MR. HLAVINKA: I guess we should mark that as Exhibit Number 5 when we can. 10:40
MR. THOMPSON: And we'll do that, with one understanding on the record. These are his originals. We've provided copies already. If we mark his original, I'd like the original to go into his file and we'll provide a copy. 10:40
MR. HLAVINKA: Fair. 10:40
THE WITNESS: There was one actual correction. It was identified at a subsequent time. I noticed it was missing and verified that it is actually on this. 10:40
MR. HLAVINKA: Okay. 10:41
(Deposition Exhibit No. 5 10:41
(marked for identification.
Q. On Pages 8 and 9 of Exhibit Number 5, there's 10:41

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a series of questions about health care access, and I think we talked a while ago about whether or not BRFSS collects Medicaid information. And I gather that this document, Exhibit Number 5, includes all the questions that are asked of the interviewee, is that correct, when BRFSS is --

A. That's what we've tried to do with that document.

Q. And I see where --

A. And again, I think there might be some errors as I identified there.

Q. I see on Page 9 that the question in '96 or '97 was asked whether or not the subject had Medicare, but I see nothing about Medicaid. Can you find anything about Medicaid on the questionnaire?

A. That -- okay. Actually, it's in the next question, "What type of health care coverage do you use to pay for most of your medical" -- I think that's a typo. "Medical care," I believe, is the wording on that question, and the options include Medicaid.

Q. All right.

A. I believe that is the way that that appears

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on that. 10:42
Q. All right. And was that asked, then, in 1996 10:42
and '7 -- 10:42
A. Yes.
Q. -- according to that questionnaire? 10:42
A. Yes. 10:42
Q. All right. Does the BRFSS ask any 10:42
information regarding whether or not the 10:42
subject is an employee of Texas A&M or the 10:43
University of Texas system or the State? 10:43
A. No. 10:43
Q. Okay. Does it ask any question regarding 10:43
whether or not the subject has accessed the 10:43
charity hospitals in the state, i.e. the 10:43
Chest Hospital in Tyler and the M.D. Anderson 10:43
and the hospitals at Southwestern and John 10:43
Sealy and other such hospitals? 10:43
A. No. 10:43
MR. HLAVINKA: Put this back in the 10:43
stack. 10:43
MR. THOMPSON: And I'll make sure 10:43
we get a copy. I'll set them aside. 10:43
MR. HLAVINKA: Jeff, if we could 10:43
have an agreement, I'm going to make a 10:43
personal listing of these things after we 10:43

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finish here at that stage in time, and then if in comparing what I have with what Tom has there are some things that are not here, will you send me copies of them? 10:43 10:44 10:44 10:44

MR. THOMPSON: Absolutely. 10:44

MR. HLAVINKA: Sounds good. 10:44

MR. THOMPSON: And just let me know. If I can send a whole new set of what I sent to Tom, I'll be happy to do that as well. 10:44 10:44 10:44 10:44

MR. HLAVINKA: Okay. 10:44

Q. There is an array of documents here on the table before us, Dr. Huang. And were these items that are here before us on the table, were they part of your file on this case? 10:44 10:44 10:44 10:44

A. Yes, they were. 10:44

Q. Okay. And I take it that you must have, at least to some extent, reviewed all of these items, looked at parts of them. 10:44 10:44 10:44

A. I believe that's a fair characterization, yes. 10:44 10:44

Q. Have you ever testified as an expert before, either before some administrative agency or before a court? 10:44 10:44 10:44

A. Yes. 10:44

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Q. Can you tell me about your experience in that regard? 10:45
A. It was regarding an infectious disease outbreak in Illinois and -- well, I guess in a deposition setting? 10:45
Q. Any setting, deposition or administrative hearing or in court. 10:45
A. Can you clarify administrative hearing or -- 10:45
Q. Before some legislative body or before some regulatory body. 10:45
A. Part of my job requires providing information sometimes to the legislature or to other governmental agencies to serve as a resource and provide information. 10:45
Q. And that's part of your routine work in your position with the State? 10:45
A. Yes. 10:45
Q. All right. But have you ever been retained by any person or entity to testify as an expert for a fee? 10:45
A. The only -- again, there was one deposition that I was asked to do when -- for an infectious disease outbreak in Illinois that I just participated in a deposition, and I think they paid for my airplane flight and 10:46

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compensated a little bit just to -- 10:46
Q. Is that the extent of your expert testimony 10:46
outside of your job responsibilities with the 10:46
State? 10:46
A. Yes. 10:46
Q. All right. 10:46
A. To the best that I can remember, yeah. 10:46
Q. Are you -- in this case, are you working 10:46
within the scope of your employment with the 10:46
State or have you been especially retained to 10:46
be an expert in this case for some additional 10:46
fee? 10:46
A. I'm working within the scope of my employment 10:46
within the State. 10:46
Q. Tell me, please, Doctor. What areas of 10:47
science do you consider yourself to be an 10:47
expert in? 10:47
A. I guess -- can you clarify how you would 10:47
define that or -- 10:47
Q. Are there any areas of science, medicine 10:47
being one, in which you consider yourself to 10:47
be an expert? 10:47
MR. THOMPSON: And I think what 10:47
he's asking you to do is clarify what you 10:47
mean by expert. 10:47

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Q. Okay. Have special training. Is there some area of science where you have special training outside of medicine? 10:47
A. I would say that I have had special training in public health, in epidemiology. Those are some -- 10:47
Q. Let me list a group of things and see if you will tell me whether or not you consider yourself to be an expert in these fields. Cardiology? 10:48
A. You know, again, no, I would say I have -- as a physician have training in some of the basic sciences, in different areas, but again -- 10:48
Q. But beyond that -- 10:48
A. Defining, I did not do a residency in cardiology. 10:48
Q. You said that you are an expert in epidemiology? 10:48
A. I have had additional training, supplemental training in epidemiology and public health. 10:48
Q. Now, was that what you received at Harvard School of Public Health? 10:48
A. It was a master in public health. 10:48
Q. And you got your training in epidemiology in 10:48

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that program? 10:48
A. It was -- I was actually in the health policy 10:48
and management program, and I believe I also 10:49
qualified -- the program as it was doesn't 10:49
designate any concentrations. I believe that 10:49
I had the number of hours if I had chosen to 10:49
do -- be in the epidemiology program, but 10:49
again, I was -- I was in the health policy 10:49
and management program. 10:49
Q. Well, I know that any regime in public health 10:49
is going to involve some work in 10:49
epidemiology. But have you had any special 10:49
training, outside of what one with a master's 10:49
in public health would have, in that 10:49
particular pursuit? 10:49
A. The CDC's epidemic intelligence service is a 10:49
field training in epidemiology and is 10:49
recognized as such. 10:49
Q. What is epidemiology? 10:49
A. The science -- you know, there are many 10:49
definitions. I would say the science of 10:49
looking into the cause -- causes of diseases 10:50
in populations would be one aspect and 10:50
characterization of that. 10:50
Q. Is it more correct to say that it's the 10:50

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science that has to do with studying the prevalence of disease rather than the cause of disease? 10:50

A. I would say that -- I would say that prevalence is included in looking at the issue. 10:50

Q. Have you ever taught a course in epidemiology? 10:50

A. I have, I think, again, like the class session that I participated in at the school of public health. That session I believe was an epi course, but I have not been an instructor in an epidemiology course per se. 10:50

Q. Have you ever published anything in the area of epidemiology? 10:51

A. Yes. 10:51

Q. In peer reviewed journals? 10:51

A. Yes. 10:51

Q. Are those listed on your CV? 10:51

A. Yes. 10:51

Q. Have you ever served on a peer review panel in the field of epidemiology? 10:51

A. Could you clarify -- are you talking about -- what are you talking about for how you would define that? 10:51

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Q. Well, a peer review journal has a panel of experts. 10:51
A. For a journal. 10:51
Q. Yes. 10:51
A. You're saying for a journal article.
Q. Yes.
A. Yes, I have reviewed journal articles, yes. 10:51
Q. Do you regularly subscribe to journals that deal specifically with the science of or with the pursuit of epidemiology? 10:51 10:51
A. I think we get many journals that certainly have epidemiologic reports, so -- 10:52 10:52
Q. Okay. We, being the Department of Health? 10:52
A. The Department of Health, my bureau. You know, I mean, there are epidemiologic reports in many medical journals. 10:52 10:52 10:52
Q. To whom do you report, by the way, in your organization? Who is your direct boss, in other words? 10:52 10:52
A. Doctor Diane Simpson. 10:52
Q. What's her job with the agency? 10:52
A. She's the associate commissioner for disease control and prevention. 10:52 10:52
Q. And how large a staff do you have under you? 10:52
A. Counting regional staff that are funded in 10:52

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our programs, you know, maybe 120. In the central office, 80, 90, somewhere around there. It fluctuates. 10:52 10:52 10:52

Q. Now, you also said a while ago that you consider yourself to be an expert in public health. And I understand that. What is public health? What is the field of public health? Can you describe that for us? 10:53 10:53 10:53 10:53 10:53 10:53

A. I would say -- well, let me -- again, I said I had special training in public health. And I would say public health is the -- dealing with trying to improve the health of populations. 10:53 10:53 10:53 10:53 10:53

Q. By what means? 10:53

A. One of the core sciences of public health is epidemiology. I think that there are now some -- the Institute of Medicine in 1988 had some definitions of some core functions of public health. And so in terms of means, they were characterized as assessment, assurance and policy development. So that might be some of the main means. 10:53 10:53 10:53 10:53 10:53 10:53 10:54 10:54

Q. What kind of training have you had in statistics? 10:54 10:54

A. I had some statistics course during my master 10:54

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of public health. 10:54
Q. Okay. How about back at Rice? 10:54
A. At Rice? Yeah, I had some statistics at Rice. 10:54
Q. Do you hold yourself out or have you ever held yourself out as being an expert in statistics? 10:54
A. No, I do not consider myself a statistician. 10:54
Q. Aside from the materials that we have arrayed here before us on the table and the materials that -- and the materials that I have handed back to Mr. Hull previously, are there any other things that you have gathered yourself in connection with your appearance as an expert witness in this case? 10:54
A. Not specifically for this. Again, I mean, I have many -- I mean, I would say that I have many materials that I review for my day-to-day work that -- 10:55
Q. Is the process of gathering information in support of your opinions in this case a continuing process or have you -- have you completed that process at this point? 10:55
A. Could you repeat that again? 10:55
Q. Are you still collecting stuff to go into 10:55

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your file on this case? 10:55
A. I believe -- I think there is some certainly 10:55
ongoing review. You know, again, I think 10:55
there were some materials that I was going to 10:55
look at at some point. I would think that 10:56
there may be some other things that come up 10:56
that seem relevant. 10:56
Q. Are you intending to pursue any specific area 10:56
of document gathering? 10:56
A. Again, I think that I would like to -- you 10:56
know, if there are things that seem relevant 10:56
that would be helpful to the case, would 10:56
certainly be open to looking at relevant 10:56
items. 10:56
Q. Right. I understand that, but I guess my 10:56
question is, is there something that you are 10:56
just anxious to put your hands on and you 10:56
haven't got to it yet? 10:56
A. I would say one thing that I am interested in 10:56
is some of the BRFSS data that's coming 10:57
available. 10:57
Q. Current stuff, stuff that comes out 10:57
currently? 10:57
A. Right. 10:57
Q. What is the latest publication or BRFSS data 10:57

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that you have been able to look at? 10:57
A. As I included in that one supplement, again, did some runs of some '96 data, and that was the first that we had looked at that data set. 10:57
Q. Have you had your charges, the people that work under you, have you had them do any special studies in order to assist you in developing opinions in this case? 10:57
A. I -- I did ask the Cancer Registry included in that supplemental information that you had, I asked them to run some cancer incidence reports for some data for 1992. And that was still preliminary. They haven't been released yet, so I wanted to get what we had currently. 10:58
Q. Your special interest there was just to update what had been gathered before; is that right? 10:58
A. Actually, the current -- 1992 will be our first year in Texas to have statewide cancer incidence data. So I was trying to actually get some actual statewide data regarding cancer incidence of tobacco-related cancers. 10:58
Q. Is that information that has to do with 10:58

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regional assessment of the incidence of cancer, or how is that done? On what basis is it done? 10:58

A. The run that I included in there is only just a statewide. It could be pulled by region. Although, again, it's still preliminary data, but, yeah, I mean, it could be ultimately pulled by region. 10:58

Q. Is there within your department -- as far as you know, is there any publicly available document that does break out cancer incidence across the state on a regional basis? 10:58 10:59

A. In terms of -- not of actual cancer incidence data. There may be some documents that have projections or estimations, but again, 1992 is the first year that we will have statewide cancer incidence data, and that data set is still being finalized and cleaned up. 10:59

Q. Can you tell me how the BRFSS survey is conducted? I know of the questionnaire's contents now from having looked at Exhibit Number 5, right? Right? 10:59

A. Yes. 10:59

Q. And --

A. What did you say? 10:59

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MR. THOMPSON: Number 5 isn't the questionnaire. It's the summary of the questionnaire. 10:59

Q. Right. 10:59

A. Yeah. 10:59

Q. The listing of questions. 11:00

A. Yeah. It's a summary of some of the questions out that have been asked. 11:00

Q. Are the -- are the surveyors full-time employees of yours? 11:00

A. No, they're not. 11:00

Q. Who are they? 11:00

A. We contract with the Office of Survey Research at the University of Texas to actually conduct the telephone interviews. 11:00

Q. What kind of personnel do you specify that you want for the job? 11:00

A. They have some criteria in terms of who are selected as interviewers. They do the training, they do the quality control and have a whole set of criteria for standards in their interview selection. 11:00

Q. Who is it that prescribes the scope of the questions that are included in the survey? 11:00

A. There is a core questionnaire that at the 11:00

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national level every state includes. There are then some optional modules that are developed at the national level that states can include to use, and then there is an opportunity for state-added questions. 11:00 11:01 11:01 11:01 11:01

Q. And if you -- if you were to add questions here that are state specific to Texas, would that be your job or someone else's job? 11:01 11:01 11:01

A. I would be involved in that selection. 11:01

Q. Okay. Is there any particular section of Exhibit Number 5 that breaks out the state specific questions that are asked here, or are they just mixed in with the rest? 11:01 11:01 11:01 11:01

A. At the very end of this there are the state-added questions. 11:01 11:01

Q. All right. Thanks. How many surveyors are involved in the statewide effort to gather the information? 11:01 11:01 11:01

A. The number of interviewers -- 11:01

Q. Yes. 11:01

A. -- conducting the interviews. I'm not -- I don't know how many actual interviewers they employ at the Office of Survey Research. 11:01 11:02 11:02

Q. Do you know how the interviews are conducted? 11:02

A. I know that they use a computer-assisted 11:02

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telephone interview.

Q. Do you know how the interview subjects are selected?

A. I know the procedure that we've been using for getting the telephone numbers.

Q. And what is that procedure?

A. Well, up until 1994 -- before 1994, we used the Mitofsky-Waksberg method of collecting the telephone numbers. From 1994 on we've purchased a sample from a commercial entity.

Q. This Mitofsky-Waksberg sample approach, can you describe that for us?

A. Its approach -- there are banks of numbers, I think the -- all of the possible numbers, including the area code, the three-digit prefix, and then the next two digits are -- for the state are collected or there's a random sample of those numbers. The procedure then -- taking that random sample, there's a random sample of the final two digits that's created. The very first one on that, the number is called. If it's a private residence, if it's a home, a household, then that whole bank is included in the sample. If it's not, then that bank

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is discarded. Then those -- those that make it past that that have the household in that sample are included as the primary sampling units. Then that randomization again of those final two digits are -- those numbers are called for those primary sampling units. They are called until there are three successful interviews in each of those primary sample units, and then when that -- when they reach a household, there's another randomization of adults that live in that household.

Q. Do you know whether the interviews are conducted only of the adults or are they conducted of others than adults?

A. They're only conducted on adults.

Q. All right. And are they all telephone interviews?

A. Yes.

Q. And is there any effort made to assure an even distribution -- rather, a proportional distribution across the state, or is the method solely or strictly random?

A. The Waksberg, that was random.

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Q. And how about the system that you've been using since what year now? 11:04
A. 1994. 11:04
Q. Is there any effort there to make for a proportional distribution of any of your subjects across the state, or is that also a random method? 11:04 11:05 11:05 11:05
A. Would you clarify what you mean by that? 11:05
Q. Well, I mean, if, for example, you have 100 people living in Houston and 10 people living in Podunk, would you select or make an effort to select 10 times as many interviews from Houston as you would from Podunk? 11:05 11:05 11:05 11:05 11:05
A. In our standard selection, we don't. We have done some specific supplements to try to over-sample some populations. 11:05 11:05 11:05
Q. Okay. And how is the system that's been used since '94 been carried out? 11:05 11:05
A. Again, we purchase a sample from survey sampling, and those -- that sample then is given to the researchers -- 11:05 11:05 11:05
Q. And do you know how this outfit from whom you buy the sample goes about selecting the sample? 11:05 11:05 11:05
A. I don't claim to be an expert on that. I am 11:06

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familiar with how it is described in the methodology for the random sampling. It's similar to the Waksberg. The one difference is that they actually do a check of listed households, and if that bank does not -- if that bank of 100 phone numbers does not have a listed household, then that bank is thrown out. 11:06

Q. Given that you changed sample selection methods in '94, are you satisfied that data collected before that time is comparable to data collected after '94? 11:06

A. We feel comfortable with the results that we have been getting. 11:06

Q. Why was that change made? 11:06

A. We made it -- I think it was to try to improve some of the -- I guess it was -- there have been some studies conducted in some of the other states looking at the comparability of doing that, and I think it was at the recommendation also of the people at the University of Texas. They had had some good success with doing that, and I think it was felt to be a little simpler system. 11:07

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Q. I take it that the system, since it relies upon telephone interviews, does not include people who for any reason, whether it's finances or otherwise, don't have a telephone at home. 11:07
A. Right. Right. I mean, it's a telephone survey. This is a telephone survey sample of the adult population, and people who don't have a telephone would not -- 11:07
Q. In your follow-up surveys, do you make any effort to penetrate that portion of the population that is without a telephone? 11:07
A. We do not. 11:08
Q. Okay. 11:08
A. I do know that the telephone coverage in Texas, I think from the 1990 census, is about only 8.6 percent of the population that does not have a telephone. So we're getting 91.4. We have that from 1990. I think that these are -- you know, we know that there are some limitations. We understand some of the limitations. It's a good survey. We feel good about the data. It's a nationally recognized survey. It's something that I use -- we use all the time for making public 11:08

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health decisions and that generally in the public health community it's well respected for its use. And as a matter of fact, I think two years ago the Council of State and Territorial Epidemiologists, which is the group of all the state epidemiologists for every state, unanimously recommended that tobacco use, adult tobacco use be included on the National Public Health Surveillance System. This was the first time there was ever a behavioral risk that was put on that system. It's normally been infectious diseases. And the data source that was recommended for that data collection was the Behavioral Risk Factor Surveillance System.

Q. And how long has the BRFSS survey been conducted in Texas?

A. We had two -- I think there were some pilot years in like 1982 and 1984, and then we have been running it from 1987 on continous -- as a continuous surveillance. I believe it's 1982 and 1984. I'd have to double-check that that was the exact years that the pilots were conducted.

Q. Doctor, I have a copy of the list of opinions

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that has been provided to us in your Exhibit Number 4 there that's before you. I think that's Number 4, isn't it, Doctor, to be sure. 11:09 11:10 11:10 11:10

MR. THOMPSON: If you're going to shift gears, could we take a short break? 11:10 11:10

MR. HLAVINKA: Yeah. You bet. 11:10

THE VIDEOGRAPHER: We're going off the record at 11:09 a.m. 11:10 11:10

(RECESS) 11:10

THE VIDEOGRAPHER: Back on the record at 11:20 a.m. 11:21 11:21

Q. Now, Doctor, you have prepared a disclosure report here, have you not, as part of Exhibit Number 4? Do you have that before you? 11:21 11:21 11:21

A. Yes, I do. 11:21

Q. Can you tell me how this item was prepared, what the procedure was by which it was done? 11:21 11:21

A. I think by phone talked to Jeff Thompson first and discussed which areas I was going to be asked to testify regarding and again talked through some issues, and then it was drafted. 11:21 11:21 11:21 11:21 11:21

Q. Was it drafted by you or by someone else? 11:21

A. I believe probably Jeff did the -- Jeff did 11:21

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the actual drafting of the details of this statement. 11:21 11:21

Q. So there was someone not under your direct supervision, though. It was not done by you or by someone that you boss at the office? 11:21 11:22 11:22

MR. THOMPSON: He's my boss in this regard. 11:22 11:22

A. Yeah, again, I would say we talked about some things, and it was drafted based on our discussions and some of the materials that I provided. 11:22 11:22 11:22 11:22

Q. And then was it submitted to you for final approval? 11:22 11:22

A. Yes. Again, just discussed it and, yes. 11:22

Q. But did you actually see it as you were discussing it? 11:22 11:22

A. No, I don't think I saw it. No, I didn't see it as we were discussing it. 11:22 11:22

Q. And this list of documents that are attached to your opinion list, was that list one for which you had input, or was it one that was compiled by someone else? 11:22 11:22 11:22 11:22

A. Again, Jeff came out to my office and we collected some materials together, and, you know, again a lot of the materials that we 11:22 11:23 11:23

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put together are included, and then there were some other supplemental publicly available documents that were added to the list as being good resources. 11:23

Q. I understand, but, I mean, were they added by you or were they added by someone else? 11:23

A. Again, some of them I provided to Jeff and he made copies. Some of them, I think he added the specific documents in there. 11:23

Q. There's that list of public available documents that we've discussed earlier. Then there's the other listing, Pages 2 through 6, that we discussed earlier. Did you have any input at all in preparation of Exhibits -- or Pages 2 through 6 of this exhibit? 11:23

A. No. I had -- I mean, I guess given the context of, you know, one of the studies that I had done regarding marketing, I think that particular study looked at attitudes of kids to tobacco advertisements, and I think it was felt that -- that's sort of the response that results, and not knowing whether there was an intention or whatever on the part of the industry that leads to that result, I think that's why some of these documents were 11:24

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included because I think they might address some of those issues in terms of again, I looked at the result of how kids responded to cigarette advertising and how much they liked it, and whether that was intended or not, I don't know. 11:24 11:24 11:24 11:24 11:24

Q. But I take it -- I take it that since you did not -- you have not referred to any of those items on Pages 2 through 6, that it was not you that is responsible for the fact that they're displayed or arrayed on that listing. 11:24 11:24 11:24 11:24 11:24 11:24

A. As I mentioned earlier, I have not reviewed all of these. I have not seen -- again, I've probably been able to see some over his shoulder as he was looking through. That was the extent of what I actually looked at, although they mentioned that they would like me to look at some of these. 11:24 11:24 11:25 11:25 11:25 11:25

Q. And not that there's any wrong with it, Doctor, but I just want to establish whether or not you instructed anybody to put any of the items on Pages 2 through 6 on the listing. 11:25 11:25 11:25 11:25 11:25

A. Again, I think that there was, you know, I 11:25

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mean, talking about the cigarette advertising and the effect on kids. I think, you know, there was probably some discussion or maybe some suggestion that there might be some internal documents or something -- 11:25

Q. And that's about as far as your discussion went? 11:25

A. Right. 11:25

Q. Okay. 11:25

A. Right. I did not come up with this list. 11:25

Q. Have you prepared any exhibits for use at the trial of this case or been involved in the preparation of any exhibits for use in the trial of this case? 11:25

A. For -- you mean, things that -- can you clarify? Things that are going to be at the trial, like -- 11:26

Q. Yes, any documents that you intend to present at the trial as being -- or in connection with your testimony. 11:26

MR. THOMPSON: You talking about documents or demonstrative? 11:26

A. Yeah. You mean like posters or what do you mean? 11:26

Q. We'll cover both separately. Let's talk 11:26

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about documents themselves. Have you prepared any kind of document or submitted to counsel any kind of document that you want to present in the course of your testimony? 11:26

A. I mean, I think all the materials that we put together and all of this -- I'm not -- I don't understand the legal system or all that. I mean, I assume they're part of -- I don't know if they're called exhibits. 11:26

Q. I guess it's fair for you to, you know, perhaps intend or make some decision at some point to present some of these items that are on the table and that have been given to us and are now in Mr. Hull's hands at the trial, and that's fine. But aside from these items, have you prepared anything that you intend to present or might present at the trial? 11:26

A. As I mentioned, you know, I mean, I think that there are -- there may be some materials that I become aware of or in the interim that if they seem to be relevant and appropriate and would add something, I would certainly be open to that. And again, you know, these other documents that are listed there, I haven't reviewed them. I have been asked to, 11:27

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so -- 11:27
Q. So to this point you have not prepared 11:27
anything or compiled anything other than what 11:27
we have here before us? 11:27
A. Right. 11:27
Q. Okay. And I take it that you have not done 11:27
any work in either preparing or assisting in 11:27
the preparation of some kind of great big 11:27
chart or other kind of exhibit that might be 11:28
placed before the jury to assist you in 11:28
explaining what you're going to testify 11:28
about. 11:28
A. When the suit was first being announced, I 11:28
know our office provided some data to the 11:28
attorney general's office that I believe some 11:28
of it might have been -- a chart might have 11:28
been blown up and used at that press 11:28
announcement. 11:28
Q. All right.
A. I don't know whether that same thing would be 11:28
used at a trial or whatever, but -- 11:28
Q. And one of the things that's here before us 11:28
on the table is a -- what appears to be 11:28
reproductions of a series of slides, and I'll 11:28
ask you what this represents. 11:28

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A. That was the slides, as much as I could piece together, from a presentation that I made up at the Centers for Disease Control regarding some research that I did while I was an EIS officer. 11:28 11:28 11:29 11:29 11:29

Q. When was this done? 11:29

A. The presentation or -- 11:29

Q. Yes, the presentation and then the study that underlies it. 11:29 11:29

A. Let me look at my CV in terms of actual date of that. 11:29 11:29

Q. Oh, well. Give me your best recollection. That's good enough. 11:29 11:29

A. I think probably -- the presentation was probably April of 1990, something like that. 11:29 11:29

Q. Okay. 11:29

A. And the research was done between -- no, I'm sorry. '92 -- probably '92, and then the research was done between 1990 -- '91 and '92. 11:29 11:29 11:29 11:29

Q. Just under the stack of slides that we've alluded to, there's a -- what appears to be a script for your presentation. Is that what this item is? 11:29 11:29 11:29

A. Yes, yes. 11:29

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Q. Okay. And did you publish anything in a peer review journal regarding the study that was the subject of this slide presentation? 11:30
A. Yes. 11:30
Q. Okay. What journal was that in? 11:30
A. Tobacco Control. 11:30
Q. And, of course, that's listed in your CV, is it not? 11:30
A. That's that article. 11:30
Q. The journal article was called "Black/White Differences in Appeal of Cigarette Advertisements Among Adolescents"? 11:30
A. Yes. 11:30
Q. And where was that study conducted? 11:30
A. As I mentioned -- maybe I didn't mention. It was conducted while I was with the Centers for Disease Control assigned to Illinois. 11:30
Q. So it was done among Illinois youth? 11:30
A. Well, one thing I should probably clarify. Earlier you had asked, you know, were my activities in Illinois. I mean, I think in terms of relevance or whatever, I think that certainly some of the work that I did with CDC in Illinois has implications or things can be learned from that in other states. 11:31

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Again, what we learn from the cyclospora outbreak in Illinois has been used across the country in evaluating and learning about cyclospora. And again, I would say that there might be the same implications for that study that was done. 11:31

Q. But certainly in matters of attitudes that might prevail among youth are a little less transferable from geographical point to geographical point than the action of a bacterium; isn't that right? 11:31

A. I wouldn't say that. I really wouldn't say that. 11:31

Q. Okay. Who is Dr. Howe and Dr. Sosin and Dr. Burton? 11:31

A. Dr. Howe is -- I guess she was one of my supervisors in -- at the Illinois Department of Public Health. I think she's head of the -- I can't remember if it's a branch, but the epidemiology -- Division of Epidemiology or something like that at the Illinois Department of Public Health. Or epi studies division, maybe. Dr. Sosin was my field supervisor at the Centers for Disease Control in Atlanta. Dr. Burton was a 11:32

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researcher at the University of Illinois-Chicago, Prevention Research Center -- 11:32

Q. I'm going to --

A. -- and School of Public Health at the University of Illinois. 11:32

Q. I'm going to let the others ask more about this if they choose because they will have a chance to have looked at it, but I will ask you one more question about it. Is there any particular part of your slide presentation or of the published material that was the basis for the slide presentation, upon which you are specifically relying in your opinions in this case? 11:32

A. I believe paragraph -- or Number 4 in the statement is directly related to that. 11:33

Q. The entire paragraph? 11:33

A. Much of it. I mean, it's related. Whether that's the sole source for the development of that paragraph or not -- yeah, I mean, it's related to Paragraph 4 in that statement. 11:33

Q. Are you saying that the data that is implicit in some of the statements in Paragraph 4 is actually reflected in the slide presentation 11:33

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or in the published article? 11:33
A. It is -- I would say that -- right. The 11:33
information in Paragraph 4 reflects some of 11:33
the information that was presented in that 11:33
slide presentation. I think that there are 11:34
other sources of information that supplement, 11:34
you know, some of the statements in that 11:34
paragraph. And again, I think that's where, 11:34
you know, some of these other internal 11:34
documents and things might be relevant and -- 11:34
Q. There are -- as I see it, there are two types 11:34
of information contained in Paragraph 4. One 11:34
has to do with, you know, advertising and the 11:34
way in which advertising might affect 11:34
adolescents. And then at the end you talk 11:34
about -- in the last sentence you talk about 11:34
the age at which people initiate smoking. Is 11:34
all of that a matter that's in these 11:34
documents that we just talked about, or is it 11:34
only the advertising related stuff that's 11:34
included? 11:34
A. The study itself and that slide presentation 11:34
is dealing with the advertising. There was a 11:34
statement as a background in the report that 11:35
refers to some of the other initiation. But 11:35

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again, I would say that there's other supplemental research and information that talks about age of initiation and things like that. That research study was not regarding and assessing age of initiation. 11:35

Q. Okay. Have you had any occasion to be in contact with any other persons who you understand might be expert witnesses in this case for the State in connection with your work on this lawsuit? 11:35

A. Could you clarify that? 11:35

Q. That is, since you've been told that you'll be an expert witness in this case, have you had any occasion to have a personal contact or by telephone with anyone else who you understand will be a witness on the case? 11:35

A. Yes. 11:35

Q. With whom? 11:35

A. Dr. David Smith, former commissioner of health. 11:35

Q. Anybody else? 11:35

A. Not that I can think -- I mean, I don't know all the witness lists or anything. 11:36

Q. Right. Can you tell us about the specific content of the contact with Dr. Smith? 11:36

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A. He had asked us, myself and the staff in the Offices of Tobacco Prevention and Control, to just try to help him describe some of the things that we had done at the Health Department during the time that he was commissioner. 11:36

Q. Okay. Have you had any contact at all, either by personal or telephone contact or by having read materials prepared by a person named Wendy Max? 11:36

A. I have seen the -- I mean, an article written by her. I glanced at it. I am not familiar with it. 11:37

Q. All right. Now, the item that you have before you, the listing of opinions, let's go over these, and let me ask you first the overall question: Does this document list all of the opinions that you intend to express upon the trial of this case? 11:37

A. I'm not sure. Can you clarify that? 11:37

Q. Well, I think that you were called upon with the assistance of your lawyers to prepare a listing of all the opinions that you intend to express upon the trial. And my question is simply, does this item that you have 11:37

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before you, Exhibit Number 4, contain everything that you -- at least by descriptive categories, all the opinions that you intend to testify to at the trial? 11:38

A. I guess I have a question, and I don't know -- I mean, if I'm asked an opinion, a personal opinion during the course of something, then I suppose there might be, you know, something beyond this. So I don't know how to answer that. 11:38

Q. I understand. My question is this: Does the exhibit reflect the essential scope of your intended testimony? 11:38

A. Yeah, I guess so. 11:38

Q. All right. You won't get into matters of -- well, cardiology or some other thing that's not broached in this listing of opinions; is that correct? 11:38

A. I believe it is accurate to say this is the list of opinions that I have been asked to testify on. 11:39

Q. Are there any opinions that you had told the lawyers that you wanted to express or discuss at the trial that for some reason were not included in this report? 11:39

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A. Not -- I don't recall saying I wanted to testify. I mean, again, it was seeing where I could fit in and what I can offer and what information I might have to help. 11:39

Q. In working on this case, have you had any contact whatsoever, as far as you know, with any Medicaid recipients? 11:39

A. Can you define contact? 11:40

Q. Well, I mean, have you done any interview of any Medicaid recipient, any examination of a Medicaid recipient? Have you reviewed any records of a Medicaid recipient and things in that category? 11:40

A. As I mentioned earlier, I do a clinic a half a day a week. I may -- I'm not sure what their insurance status is. There may be some Medicaid patients. 11:40

Q. So if you -- if there has been such contact, it's been strictly incidental to your work in the clinic? 11:40

A. As far as I know, yes. Again, in terms of defining contact. 11:40

Q. Well, in terms of defining contact, I'm talking about interview or examination or study of charts or study of other data that 11:40

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pertain to the physical health condition of Medicaid recipients. You have had no opportunity to do that except insofar as you may have incidentally seen some Medicaid people in your clinic? 11:40 11:40 11:41 11:41 11:41

A. I -- yes, I have seen some -- I mean, I have seen, yeah, possibly some Medicaid people in my clinic. I may have seen a Medicaid report on hospital discharge data or some -- you know, something like that. 11:41 11:41 11:41 11:41 11:41

Q. But in specific relation to any individual patient, you have not reviewed records, have you? 11:41 11:41

A. I have not reviewed records of any Medicaid patient that I know of. 11:41 11:41

Q. Is anyone working with you as a part of a task force to assist you in being an expert in this case, or is this a one-man operation with the assistance of your lawyers? 11:41 11:41 11:41 11:41

A. I think that in terms of, you know, collecting some materials, I have, you know, worked with some of our staff at the Texas Department of Health to maybe identify some materials, get some articles or whatever. So, you know, there are people who might help 11:41 11:41 11:42 11:42 11:42 11:42

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copy something or get some articles at the health department. 11:42

Q. Aside from those who may have performed clerical functions for you, copying and typing, have you had anyone assist you in pulling together statistics or pulling together any other information that you have relied upon in working on this case? 11:42

A. Yes. As I mentioned, like we just did some runs on some of the Cancer Registry data and some of the BRFSS data. 11:42

Q. Let's look at the report now and go over it line by line, if we could. Your first statement in the report is that you're liable to testify that smoking is the single most preventable cause of cancer and death in the United States and in Texas today; is that correct? Is that your statement? 11:43

A. Yes, I believe that -- I believe that smoking is the single most preventable cause of death and disease in Texas and in the country. 11:43

Q. What are some of the other preventable causes of cancer and death in the U.S. and Texas that you have considered in making this comparison? 11:43

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A. I would say -- when I make that comparison, I'm not talking necessarily about preventable causes of cancer. I'm looking at preventable causes of death and disease. So, you know, one of the statements that -- and the data that we typically use is that tobacco kills more than AIDS, crack, heroin, cocaine, alcohol, car accidents, fire and murder combined. 11:43 11:43 11:43 11:43 11:43 11:43 11:44 11:44

Q. I've heard that on the radio, but I'm talking about what's the basis for your saying that,, and if you're talking about comparing it with other causes, I'm wondering what other causes are you comparing it with. 11:44 11:44 11:44 11:44 11:44

A. Again, I would say -- 11:44

Q. That listing? 11:44

A. That listing. Certainly when you look at those numbers, I mean, those particular issues, and we look at the vital statistics data and make that comparison, that's -- those are conceivably preventable, and that tobacco use, the mortality associated with that is tremendous compared to those preventable causes of death and disease. 11:44 11:44 11:44 11:44 11:44 11:44 11:44

Q. You say you look at the vital statistics 11:44

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data. Is that what you said you look at? 11:45
A. Yes. Well, I said -- yes, looking at death 11:45
certificate data, vital statistics and, you 11:45
know, some of the calculations for 11:45
smoking-attributable mortality that are made. 11:45
Q. Is that information accumulated and published 11:45
somewhere in some publication, or is this 11:45
just an off-the-top-of-your-head kind of 11:45
assessment of the death certificate 11:45
information? 11:45
A. One of the resources that's listed is the 11:45
vital statistics report that has the actual 11:45
death certificate data for some of those 11:45
causes of death, yes. 11:45
Q. Of course, the death certificate doesn't list 11:45
tobacco smoking as a cause of death, does it? 11:45
A. Yes, actually -- well, the death certificate 11:45
since 1993 in Texas does have the question 11:45
"Did tobacco use contribute to this death," 11:46
and the options are yes, no, probably and 11:46
don't know. So there is since 1993 a 11:46
question regarding tobacco use's contribution 11:46
to death. 11:46
Q. And who prepares that part of the report? 11:46
Does the physician who pronounces the 11:46

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patient? 11:46
A. It is -- yes, the certifier of death. 11:46
Q. Is there any effort to look behind that to see how reliable the information might be? 11:46
A. I'm not an expert in vital -- you know, vital statistics data collection. I think, again, you know, there are limitations to any data source. We recognize those limitations. It is still very useful data that we use all the time in public health, that every public health department across the nation and the world looks at vital statistics. And in terms of assessment, death certificate data, vital statistics are one of our key sources of important information. It is -- you know, I feel that it provides us with very good information that we can make public health decisions on and that's accepted as being useful for that purpose. 11:47
Q. But I guess what I'm interested in is this: Most all disease entities, certainly the ones that are said to be tobacco-related, are multifactorial diseases, aren't they? Cardiovascular diseases are multifactorial, lung cancer is multifactorial; isn't that 11:47

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correct?

A. I would say that, you know, there are -- you know, tobacco use's contribution to a death -- I mean, there are factors that play into cause of death obviously. 11:48

Q. Well, it's true, is it not, Doctor, any time that you have a multifactorial disease entity, one cannot assert which of the factors may have been operative in any particular case or whether they were all operative or whether some were operative and others not. And if you can, then, how do you determine that? 11:48

A. I would say if I were certifying a death and, say, the patient had lung cancer and had smoked for, you know, two packs a day for 25 years and died of lung cancer, that I would feel very comfortable saying that tobacco use contributed to that death and that there are other situations similar to that where I would feel very comfortable making such an association. 11:49

Q. Well, in the lung cancer situation, would it be important to you where the cancer was located in the lung field? 11:49

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A. I think that there are certainly some types -- I mean, you know, the different cell types that are -- I mean, it's a clinic -- I would say that, you know, there's a clinical judgment in a death certificate certification that occurs and that's why, you know, the person completing the death certificate assesses the information that they know and makes that determination based on their expert opinion as to cause of death and contributory causes of death.

Q. But then awhile ago you said that if you saw a lung cancer case and a person was a two-pack-a-day smoker, you'd feel comfortable in saying that the smoking caused it, and --

A. I was trying to give an example of --

Q. Is that how the average doctor would report that?

MR. THOMPSON: Wait. Let him finish his answer, and if you'll let him finish his question, it will make her job a lot easier. Thank you.

Q. Go ahead. Do you have some more to say?

A. Well, go ahead.

Q. Is that how you instruct the physicians who

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prepare these reports to make their judgments, or are you given -- are you given any kind of instruction as to how to complete that part of the form? 11:50

A. Actually, one of the documents that I think we added to this is -- 11:50

THE WITNESS: Jeff, do you know that certificate manual? 11:50

MR. THOMPSON: I think it's that package. 11:51

THE WITNESS: This is some information put out by the Bureau of Vital Statistics. 11:51

Q. And this is put into the hands of physicians who complete death certificates? 11:51

A. I don't know -- you know, I'm not involved in their distribution of that. That is their handbook that they put out and distribute. 11:51

Q. That's called The Handbook on Medical Certification of Cause and Manner of Death, right? 11:51

A. Right. 11:51

Q. Okay. But now you would agree, would you not, that as a general matter, if a disease is multifactorial, such as, let's say, stroke 11:51

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or heart disease -- and there are many factors that contribute to those diseases, are there not? 11:51

A. I would say that there are potential factors that can -- 11:52

Q. That can contribute, right? 11:52

A. Again, I would say that there are various factors that could contribute to a stroke death. 11:52

Q. Okay. Or to a heart disease death? 11:52

A. Yes, I would say -- I would say that, yes, there are various factors that could contribute to a heart -- 11:52

Q. If, for example, you can identify in the particular heart disease patient the fact that he's male, the fact that he's over age 50, the fact that he's a smoker, the fact that he has a diet that's comprised of a high fat content, the fact that he has a high serum cholesterol level, the fact that he doesn't exercise and is sedentary, the fact that he is involved in a stressful occupation, the fact that he tends to be depressed from time to time, if you saw a patient such as that who dies, in that case, 11:52 11:52 11:52 11:52 11:52 11:52 11:52 11:52 11:52 11:52 11:52 11:53 11:53

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how can you say which of those factors caused the death or which of them were actually operating in his death? 11:53

A. I would say that one of the values of what -- that's what epidemiology and what we've learned from epidemiology and from studies that have been conducted looking at populations and comparing persons with risk factors -- various risk factors than those that don't have those risk factors and controlling for different other variables and seeing -- you know, that's sort of what epidemiology is and that there have been numerous studies looking at these. And I think that it is generally accepted by science -- well, I mean, actually, I can't say that, but I mean, I would say that I personally feel that tobacco use -- the data shows that tobacco use causes cancer. 11:53 11:53 11:53 11:53 11:53 11:53 11:53 11:53 11:53 11:53 11:53 11:53 11:53 11:53 11:54 11:54 11:54

Q. But we were -- 11:54

A. Lung cancer. 11:54

Q. You're changing questions on me, Doctor. We were talking about a particular question in a particular case. How can you say in that case that any particular one of those several 11:54 11:54 11:54 11:54

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factors actually operated in bringing about the disease that caused the death? 11:54

A. And what I was trying to bring in is again how public health information, epidemiologic research, study results, those sorts of things go into -- I mean, advance our knowledge about the contribution -- relative contributions of some risk factors for particular diseases. And we know that tobacco use is a very important, you know, cause of lung cancer. It contributes to heart -- heart disease, stroke. So is that -- do you understand what I'm trying to say to you? 11:54 11:54 11:54 11:54 11:54 11:54 11:55 11:55 11:55 11:55

Q. Well, not all persons who smoke cigarettes die of heart disease, do they? 11:55 11:55

A. No. I would say not every person who smokes dies of heart disease. I mean, I think, you know, obviously some people die of lung cancer. 11:55 11:55 11:55 11:55

Q. And a lot of folks who don't smoke die of heart disease. 11:55 11:55

A. Yes. I would say that, yeah, many people who don't smoke die of heart disease. 11:55 11:55

Q. And although the correlation with smoking and 11:55

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lung cancer may be tighter than in the case of heart disease, many people who die of lung cancer don't smoke; isn't that correct? People who work around asbestos, people whose lung cancer is not the primary site of the cancer but one that has started someplace else? 11:55 11:55 11:55 11:56 11:56 11:56 11:56

A. I think, you know, some of the data have shown like 89, 90 percent of lung cancers are related to smoking. 11:56 11:56 11:56

Q. But the fact is that many people -- many people who don't smoke die of lung cancer and many people who do smoke don't die of lung cancer. That's a fair statement, isn't it? 11:56 11:56 11:56 11:56

A. I would say, again, I mean, you know, there is a lot of epidemiologic research. I think it's accepted that probably 89 to 90 percent of lung cancers are related to smoking and tobacco use by the person. 11:56 11:56 11:56 11:56 11:56

Q. But if you're going to assert that smoking causes more deaths than anything else, what you say in your first sentence here, isn't it important to know whether in any particular reported death the smoking was actually operating in bringing about the death? 11:56 11:56 11:56 11:56 11:56 11:57 11:57

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A. I would say that, you know, that's what we do in public health and the difference between when I was doing clinical work versus public health. What we deal with as a clinician, you deal with the individual patient. As a public health officer, you deal with populations and you look at the data for populations, and there is epidemiologic data that makes those comparisons of populations and looks at persons with risk factors and without them and looks at the mortality from different diseases with those risk factors and not, and that's where the evidence and the science shows that relationship to tobacco use. 11:57

Q. What you find -- what you look for is relative risk and the odds ratios and things like that, do you not? 11:58

A. Relative risk and odds ratios are two of the calculations, certainly, that are used in epidemiologic studies. 11:58

Q. But in public health you don't look at individual patients and say this patient died from A, B or C -- A, B or C. You look at populations as a whole in your work. 11:58

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A. Could you clarify that? What are you saying? 11:58
Q. I think you said awhile ago that clinicians on the one hand look at patients, and you in the public health field look at populations and the data that's gathered regarding populations; isn't that correct? 11:58
A. Right. I would say that that's the difference, key difference between public health and an individual clinician is that public health practitioners deal with the entire population and assess -- an assessment is made of a population. 11:59
Q. Now, the next sentence in your report says, "In this regard, Dr. Huang will specifically discuss smoking-attributable mortality rates and the incidence of smoking-related cancers in Texas." Now, what will you specifically discuss about those topics? 11:59
A. We have used some of the software, the SAMMEC, Smoking Attributable Morbidity, Mortality and Economic Cause software to make some calculations for smoking-attributable mortality in Texas. I think the latest numbers are, you know, 26,427 or something is 11:59

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how -- what we have from SAMMEC. 11:59
Q. That's based upon SAMMEC, you said? 11:59
A. Yes, SAMMEC. 11:59
Q. And is that what you intend to specifically discuss when you insert in the second sentence that you will be discussing that at the trial? 11:59
A. I think also, you know, another -- as I mentioned, since 1993 we have added a question on the death certificate, "Did tobacco use contribute to this death," and we have some of the preliminary data with that. And, I mean, over 18,000 that were directly on each death certificate marked as a yes or probably that tobacco use contributed to that death, which is an amazing number. You know, I mean, these are 18,000 -- you know, 26,000. And that's with 40 percent, almost 40 percent of those death certificates marked as unknown. So even throwing out 40 percent of the deaths for that given year, close to that for a given year, that over 18,000 deaths the certifier specifically marked that yes or probably that was a tobacco-related death. It supplements and supports the

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SAMMEC data results.
Q. You might say that, but it seems to me like there's a discrepancy between the SAMMEC numbers and the actual numbers that you got on the certificates. One is 26,000, SAMMEC, right? Is that correct?
A. Right.
Q. And the actual reports of where doctors reported that either smoking did or probably caused the death was in the range of 18,000.
A. That's what those that answered yes or probably. Then as I mentioned, there's almost 40 percent that were marked unknown.
Q. Are you saying that that's --
A. So that there's this whole group that we don't know whether tobacco use did or didn't, that I think the numbers -- there was actually a study in Oregon where they had the same wording of the question on the death certificate. They had a lower number of unknowns and they did a correlation with SAMMEC, and the numbers came out very close. So I think that they're actually consistent, again given that we have such a large number that were marked as unknown.

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Q. So what you're saying is that the doctor who was attending the patient might not know what the patient died from, but SAMMEC knows. Is that the essence of what you've just said? 12:02
A. No, no. I would say the SAMMEC estimates use a methodology looking at some of the, you know, attributable fractions and come up with an estimate. And the death certificate data that we get is an estimate that is produced by looking at the data that's marked on the death certificate by the certifying physician or certifier of death and that those data are actually consistent. They are not inconsistent. 12:02 12:02 12:02 12:02 12:02 12:02 12:02 12:02 12:03 12:03
Q. Is there anything further that you intend to discuss regarding smoking-attributable mortality rates and the incidence of smoking-related cancers in Texas as stated here in this sentence? 12:03 12:03 12:03 12:03 12:03
A. As I mentioned, you know, I've just done a run of some of the incidence data that we have for 1992, so, you know, we'll have probably some better numbers of that. I might present that if that's of interest. 12:03 12:03 12:03 12:03 12:03
Q. This is data based upon what data source? 12:03

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A. The Cancer Registry. 12:03
Q. Okay. So you're looking primarily at the 12:03
Cancer Registry, at the death certificate 12:03
information that's more recently available 12:03
and at SAMMEC information in support of your 12:03
discussion of smoking-attributable mortality 12:03
rates; is that correct? Or is there more 12:03
that you're looking at? 12:03
A. Yes, I believe those are the primary data 12:04
sources, and, again, looking at comparing 12:04
some of the other death data that we have. 12:04
Q. Sure. The second paragraph is begun by 12:04
saying that Doctor Huang is expected to 12:04
testify regarding the prevalence of smoking 12:04
among adults in Texas, specifically that 12:04
nearly one in four adult Texans smoke. And 12:04
what's the source for that information? 12:04
A. The Behavior Risk Factor Surveillance System. 12:04
Q. Is there any other data source that you look 12:04
at in that collection? 12:04
A. That is our primary data source that we use 12:04
for Texas. I mean, there are some other -- 12:04
other data that is available that -- you 12:04
know, current population survey, but BRFS is 12:04
the primary data source. 12:04

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Q. What you'll be relying upon is BRFS? 12:04
A. BRFS is what we will primarily use. 12:04
Q. And what is the BRFS reported prevalence of smoking among adults in Texas? 12:05
A. The latest number I believe is 23.7 percent total, and I have the latest report in our data. 12:05
Q. For what year would that be? 12:05
A. That was 1995. Yeah, I think that's in there. It's probably right here (indicating). Have you seen that -- 12:05
Q. Right. Let me -- 12:05
A. -- table? 12:05
Q. -- read the name of the report for the record. This is the "Texas Risk Factor Report, BRFS, March 1997." And that reports the 1995 survey results, does it not? 12:05
A. I'm sorry? 12:06
Q. I said, that reports the 1995 survey results. 12:06
A. Yes, yes. 12:06
Q. Okay. And that rate again was 23 -- 12:06
A. .7. 12:06
Q. Did you say .7? 12:06
A. Yes. 12:06

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Q. How does that compare with the rate in the United States as a whole? 12:06
A. I believe it's actually -- I'm not sure 1995 data for that. I would want to compare that. 12:06
Q. In years past, how does Texas smoking rate among adults compare with the U.S. rate as a whole? 12:06
A. I believe we've been slightly under the national. 12:06
Q. Just a point or two or maybe even less than that sometimes, right? 12:06
A. Yeah. 12:06
Q. And has the Texas rate been in the range of 23 percent for quite a while, plus or minus a point or two from year to year? 12:07
A. We looked at -- yeah, from 1987 through '95, the total overall average has remained around 23 percentage points. We did look at some of the subgroups and we found there actually has been a significant increase among the 18 to 24-year-olds over that time that's sort of compensated by a little more reduction among some of the older adults. But there has been among the 18 to 24-year-olds actually an increase. 12:07

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Q. I have an item here, and I'm not sure what the source of it is. I think it may be the Internet. 12:07

MR. THOMPSON: We all know that everything on the Internet is accurate. 12:07

Q. Right. But it comes from the TDH Web page. 12:07

MR. THOMPSON: Well, then it must be accurate.

Q. The report said in 1992-3, the 18 to 24-year bracket -- year-old bracket percent was 20.8 percent. Is that consistent with what you've been finding? 12:08

A. I'm sorry. What year? 12:08

Q. '92-'93. 12:08

A. Okay. And that's -- is the source BRFS? 12:08

Q. Yes. 12:08

A. Okay. Again, that's probably one of the pilot years that we ran the study, and I'm not -- I'm not familiar with that exactly, but I mean, if it's -- I can look at it. 12:08

Q. What do you have for the year 1995 for 18 to 24-year-olds? 12:08

A. 1995 we have 22.9. 12:08

MR. HLAVINKA: We have to wait for a while now. She's got to change a tape. 12:08

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THE VIDEOGRAPHER: We're going off the record at 12:08 p.m. This is the end of Tape 1. 12:08

(LUNCH RECESS)

THE VIDEOGRAPHER: We're back on the record at 1:06 p.m. This is Tape Number 2. 13:07

Q. Doctor, if I can go back just very briefly to the testimony or to the subject of the death certificates. In those certificates, under the practices that are followed, is the certifier always a physician or does the justice of the peace or some other coroner type officer from time to time certify? 13:07

A. There are certifications by justices of the peace and coroners. 13:07

Q. What circumstances do the JPs and coroners get involved in certifying death? 13:07

A. I'm not an expert again on medical certification. However, I mean, my understanding is I think that there are some particular circumstances if -- what was it, death within 24 hours of being in a hospital. You know, there's a list of things then that have to go to a medical examiner. 13:08

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Q. Okay. And are those the only ones that you can recall? 13:08
A. Actually, I mean, I could list -- give you a good list. 13:08
Q. It would probably be stated in the handbook, would it not? 13:08
A. Right, right. I know -- 13:08
Q. We'll find it, Doctor. That's okay. Now, we're talking about the testimony that you were going to give regarding the prevalence of smoking among adults in Texas. And what testimony do you intend to give regarding that? 13:08
A. Essentially to review some of the behavior risk factor surveillance data that we have, that, again, I think currently the figure is 23.7 percent for 1995. Some of the trends that we discussed earlier, that overall for adults between 1987 to '95 at least, it's been fairly stable. However, there has been what appears to be an increase among the 18 to 24-year-olds during that time period. 13:09
Q. What age bracketing does the BRFSS data break the smoking information down into? 13:09
A. We can bracket it however we like. 13:09

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Q. How is it typically reported? 13:09
A. Let me -- can I see that report? What we did on that one, we did 18 to 24, I think -- I mean, 35 to -- I mean, 25 to 34, 35 to 44, 45 to 54, 55 to 64 and 65 plus, but I mean, we can do it different ways. 13:09 13:09 13:09 13:09 13:10
Q. All right. So do you get that data on a specific age basis when you inquire of the subject? You ask that subject how old he is or she? 13:10 13:10 13:10 13:10 13:10
A. Right. 13:10
Q. And then is the data actually collected and compiled on a per year or per age basis? Can you tell us, for example, how many 40-year-olds smoke? 13:10 13:10 13:10 13:10 13:10
A. Yes. That analysis could be -- 13:10
Q. You could break it out? 13:10
A. -- could be done. I mean, in terms of a number could be made, yes. 13:10 13:10
Q. Is there any effort to assure that there is a uniform distribution of the ages within the spectrum between, let's say, age 18 to 25, or do you simply take as many 18-year-olds as you happen to get randomly, as many 22-year-olds as you happen to get randomly, 13:10 13:10 13:11 13:11 13:11 13:11

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et cetera, et cetera? 13:11
A. Yeah. The routine operation of the survey, 13:11
we do the methodology sampling that we talked 13:11
about earlier. We have at times done some 13:11
specific oversampling of some populations. 13:11
For instance, I think this last year we've 13:11
been looking at some oversampling of 13:11
African-American and Hispanic populations to 13:11
supplement the sample. 13:11
Q. Have you made any analysis of the data that 13:11
you collect to see whether or not there is a 13:11
proportional distribution of the interviewees 13:11
along the scale of ages; that is, that you 13:11
have about as many 18-year-olds as you have 13:12
19-year-olds as you have 20-year-olds, et 13:12
cetera, et cetera? 13:12
A. I have not done that. To my knowledge, we 13:12
have not done that particular analysis. 13:12
Q. So if by random chance, let's say in the 18 13:12
to 24-year bracket, you happen to have hit a 13:12
cluster of 18-year-olds, then there might be 13:12
some skewing of the true incidence of smoking 13:12
between -- of the people between age 24 13:12
and -- age 18 and 24, would there not? 13:12
A. I would say, again, you know, the methodology 13:12

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is very well described in the procedures for doing the sampling. There is -- it's a recognized method for collecting a telephone sample, and it is designed to be representative of the adult population. 13:12 13:12 13:12 13:12 13:12

Q. But then again, without regard to age distribution. 13:12 13:13

A. Right. The sampling -- we do not particularly oversample 18 to 24-year-olds. 13:13 13:13

Q. You say that you have oversampled the Hispanic population and the black population; is that correct? 13:13 13:13

A. I believe it was -- yes, we have done those in the last year's survey. 13:13 13:13

Q. Is that reported as a part of your BRFSS data, or is it reported in some other place? 13:13 13:13

A. We have not analyzed that yet. It was just completed. That -- that data hasn't been looked at. 13:13 13:13 13:13

Q. Does BRFSS break out the ethnic and/or racial incidence of smoking? 13:13 13:13

A. We do runs looking at some of the ethnic and racial breakdown. 13:13 13:13

Q. Do you have the figures for 1995 as to what the percentage of Hispanics in Texas who were 13:13 13:13

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smokers? 13:13
A. Yeah. The 1995 figure is 19.6 percent for Hispanics. 13:14
Q. How about for Hispanic women? Do you break that out? 13:14
A. I do not have that number here. As you get into too small of a subcategory, no, I don't have that. 13:14
Q. Do you know that it is or is not available to you without going back to the raw data and pulling it out? Is it somewhere -- somewhere compiled and reported? 13:14
A. To my knowledge, it is not -- that number is not written on any report. That particular number is not written on any report that we produced. 13:14
Q. So you don't gather or produce reports that break out the gender breakdown of smoking incidence. Is that what I'm hearing you say? 13:14
A. No, that's not correct. We have male versus female data, for instance, for 1995. 13:15
Q. But not within ethnic or racial groups? 13:15
A. That's not something that we have reported on this -- on this particular report. 13:15
Q. Okay. But have you reported that in any 13:15

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particular report that you do put out? 13:15
A. I couldn't tell you definitively. I mean, it's quite possible that we have. 13:15
Q. What is the breakout of the African-American or black population smoking incidence? 13:15
A. For 1995 the figure was 27.2 percent. 13:15
Q. And how about the -- do you break out the white, non-Hispanic population? 13:15
A. We have -- yes, 24.5 percent. 13:15
Q. Do you have separate breakdowns for some categories such Asian or other or Native Americans or -- 13:15
A. There is an other category and that figure for 1995 was 19.8 percent. 13:15
Q. And that includes all others than the Hispanic, the non-white -- or the non-Hispanic whites and the African-Americans? 13:15
A. Correct. 13:16
Q. Okay. Has it been an appreciable change in those ethnic and racial breakdowns over the 10 years that you have reviewed? 13:16
A. I don't know that that specific analysis to test the trend on that has been conducted. 13:16
Q. Okay. You do state in your statement that 13:16

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you are going to testify that the prevalence of smoking among adult Texans has remained constant for the past 10 years. That's what you mentioned this morning, right? That is, the numbers look about the same, they average about 23 percent? 13:16

A. The total for the population of Texas, the total figure combining all groups has remained approximately, yeah, 23 percent. 13:16

Q. Now, that's the BRFSS information? 13:16

A. That is from Behavior Risk Factor Surveillance, yes. 13:16 13:17

Q. And, of course, that population is only the 18 year and older population, right? 13:17

A. Yes. BRFS is adult Texans. 13:17

Q. It doesn't take into account those below 18? 13:17

A. Correct. 13:17

Q. Okay. And when you make this statement here, it speaks for itself. You are saying that this is adults you're talking about? 13:17

A. Yes, this is -- the Behavioral Risk Factor Surveillance System data is adult Texans. 13:17

Q. "Dr. Huang also is expected to testify that young adults, those 18 to 24 years of age, are the only subset of the Texas population 13:17

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for which smoking prevalence is increasing." Do you see that? Is that your testimony? 13:17

A. I would say of the adult -- let me see -- where is that? Oh, okay. I would that say for adult -- of the adult population, that is, in terms of age, looking at the age groups, that that is the trend. Now, again, as I mentioned previously, we did not do a run looking at by ethnicity or race, testing for a trend, and I think that there are some trends in some of the youth smoking rates from another data source. 13:17 13:17 13:17 13:18 13:18 13:18 13:18 13:18

Q. But looking now at the adults, which is what we're talking about at this -- in this particular sentence, what data sources do you rely upon in making the assertion that there is a trend of an increase among the group of 18 to 24-year-olds as opposed to other adults? 13:18 13:18 13:18 13:18 13:18 13:18 13:18

A. The data source where that statement came was from BRFS. It's probably actually incorrect to say the only subset, because as you've pointed out, I mean, there would be some other potential breakdowns that could be looked at that may show a trend. This was 13:18 13:18 13:18 13:19 13:19 13:19

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with respect to some of these particular age categories. 13:19
Q. Can you tell us what the -- over the 10 years that we're talking about here -- and you are still talking about a 10-year trend, aren't you? 13:19
A. We're talking about from 1987 to 1995. 13:19
Q. Can you tell us what the reported incidence of smoking from the BRFSS study was back in the '87 survey for that 18 to 24 age group? 13:19
A. That particular figure for 18 to 24-year-olds in 1987 was 15 percent. 13:19
Q. Okay. And now it's? 13:19
A. 22.9 was in 1995. 13:19
Q. '95. Now -- but again, within that group of individuals who are reflected in those numbers, you don't know how many of them are 18-year-olds back in '87 or how many were 18-year-olds back in '95 at the time of the studies. 13:19
A. Could you repeat that, please? 13:20
Q. I'm saying that you don't know how many 18-year-olds were included in your '87 survey, nor how many were included in your '95 survey, do you, Doctor? 13:20

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A. No. That figure could be determined. 13:20
Q. But in the numbers that you have here, they are not reflected, are they? 13:20
A. I do not have that figure before me right now. That number could be determined. 13:20
Q. Okay. And going on up from 18 to 19 to 24, all the way up, you can't -- you have no reported data source where those particular age groups have been specified as to how many members were in those groups at the time of the surveys? 13:20
A. Again, repeat that, please. 13:20
Q. You don't know how many 19-year-olds were included in the '87 survey or how many 19-year-olds were included in the '95 survey? 13:20
A. That number can be determined. 13:21
Q. Right. But it's not reported anywhere. 13:21
A. Yes, I don't have it before me here. I'm sure there is a standard data run that might have a figure like that or it can be produced, certainly. 13:21
Q. But you would agree, would you not, that if there is a skewing of the number of persons within one age group during, let's say, the '87 survey and some other age group in the 13:21

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'95 survey, that the two numbers where you report 18 to 24, those two numbers wouldn't be comparable, would they, because one would be skewed one way and the other skewed the other way? 13:21

A. No, I wouldn't agree. I mean, that's part of why we put some groupings of the age so -- so we can look at some of these trends, you know, for an age group and to increase some of the sample size for that particular age group. 13:21 13:22

Q. But don't you suppose that smoking incidence varies somewhat between age 18 and age 24? 13:22

A. Define varies. And what are you saying exactly? 13:22

Q. There may be a higher incidence in 18-year-olds than in 24-year-olds or vice versa? 13:22

A. Are you saying on a particular -- on a particular day? 13:22

Q. Yeah, sure, in any particular survey. 13:22

A. I'm still not understanding what you're -- point you're getting at. 13:22

Q. Well, I mean, isn't it true that there is a good chance that the number of smokers 13:22

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within, let's say, age group 18 on any given day is different from the number of smokers on a percentage basis of folks who are 24-year-olds on that same day? 13:22 13:22 13:23 13:23

A. We don't report -- 13:23

Q. You do --

A. We don't report survey data on a day -- I mean, this is aggregated for a year. 13:23 13:23

Q. On the occasion of a survey, however long it takes to make a survey, on the occasion of a survey, isn't it likely that the number or percentage of smokers within the 18-year-old bracket is different, either less or greater, than the number of smokers percentage wise in the 24-year-old bracket? 13:23 13:23 13:23 13:23 13:23 13:23 13:23

A. Again, I mean, I would just -- this is a data for a whole year and it's, you know, a sample of the population for that year to get an average smoking prevalence of that age population for that year. I mean, certainly -- I mean, we, you know, have the figure 3,000 kids start smoking every single day. Again, I mean, I think that there will be new smokers that start -- you know, again, you know, probably 3,000 kids are starting to 13:23 13:23 13:23 13:23 13:23 13:23 13:23 13:24 13:24 13:24 13:24

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smoke today. 13:24
Q. On a percentage basis, Doctor, are there more 13:24
18-year-olds who smoke or more 24-year-olds 13:24
who smoke? 13:24
A. I can't tell you that right now. 13:24
Q. Now, you can tell us that there are more 13:24
males that smoke than there are females that 13:24
smoke, can you not? 13:24
A. I would say our data show that for, for 13:24
instance, 1995, during that year, 13:24
approximately 27.1 percent of the males -- 13:24
adult males in Texas smoked, versus 13:24
approximately 20.4 females for that year. 13:24
Q. Right. 13:24
A. That's -- 13:24
Q. And you're --
A. But it's not a day-by-day figure. 13:25
Q. I understand. On the occasion of a survey, 13:25
whether it's a year or 10 years or however 13:25
long you include it in a particular survey. 13:25
Now -- and at the same time, the numbers that 13:25
you have there, the 23 or four percent that 13:25
you had for the number -- for the percentage 13:25
of smokers in the 18 to 24-year bracket for 13:25
1995, what number was that again? 13:25

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A. 22.9. 13:25
Q. 22.9. That number, you don't know how many folks in the survey group were female or how many were male. 13:25
A. That data is available. 13:25
Q. It's available, but it's not reflected in -- in that average number, is it? That's simply the average of however many females there were and however many males there were. It's true, isn't it? 13:25
A. Again, could you repeat the question? 13:25
Q. It's an average of the female population and the male population that happen to be included in the survey. 13:25
A. For that age group, we -- I mean, that figure is a combined for males and females. We did not break it out by males and females. It's for that age group. 13:26
Q. Right. And if, for example, you had included a disproportionately large number of females in 1987 and on the other hand, a disproportionately large number of males in 1995, you really couldn't compare the '87 raw average with the '95 raw average, could you, Doctor? 13:26

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A. Again, what I've said, you know, we have the methodology for this is a population-based survey. There's a sample that's collected. It is, you know, to be representative of the adult population. Now, that's how the data is collected. 13:26

Q. But the --

A. And we're not oversampling any particular age group in these. It is a -- you know, essentially a sample of the adult population. 13:27

Q. You collect the information specifically with regard to males and females and age of the reporter, of the reporting respondent, but when you report it in this document that we're talking with -- or talking about, you simply report the overall average. 13:27

A. That is our choice. We -- I mean, we produced for this particular table -- 13:27

Q. Right. 13:27

A. -- the breakdown on this. This is not the only breakdown that can be produced on this. We made a selection, thought that this showed some interesting trends, but this is not the data and the way we can report this data is not limited to what you see on this chart. 13:27

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Q. Okay. Is there some other data upon which you're relying when you say that the trend has been for an increase in the smoking prevalence among the adult respondents age 18 to 24, or do you rely strictly upon this collection of data? 13:27 13:28 13:28 13:28 13:28 13:28

A. That -- the particular statement on here was based on our Texas Behavioral Risk Factor Surveillance data. 13:28 13:28 13:28

Q. Yes. But on this particular reporting of it or some other form or format of the report where more detailed information is reflected? 13:28 13:28 13:28

MR. THOMPSON: Maybe -- I mean, the distinction here is you're asking about data and he's answering your question and then you're pointing to a report. If you can be more specific maybe. 13:28 13:28 13:28 13:28 13:28

Q. Well, did you understand the question, Doctor? 13:28 13:28

A. Could you again repeat it? The data -- we have a data source, the Behavioral Risk Factor Surveillance System data. 13:28 13:29 13:29

Q. All right.

A. This is one report. This report is not, and we never claimed that this is exhaustive 13:29 13:29

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report of all the data and what this data shows. So I can't say that, you know, we might not -- the Behavioral Risk Factor System data has other information captured that might not be on this particular report. This is the report that we produced, and it exists, but again, if you asked a particular question, we can do a report and get some figure. If you wanted to know a different breakdown or something, we could get a figure for that.

Q. Let me try my question. For your statement that young adults, those 18 to 24, are the only subset of the Texas population for which smoking prevalence is increasing, what particular published information are you basing that on?

A. Again, I would probably correct it and take out only subset.

Q. Okay.

A. But I would say that this particular report does show the data that young adults age 18 to 24 have shown an increasing prevalence from 1987 to 1995.

Q. All right. Now, so you've told me that

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you're basing it upon this report, which is the one that is called what again so we have it for the record? 13:30

A. I mean, I guess -- I'm sorry. 13:30

Q. Hold it. 13:30

MR. THOMPSON: Let him answer the question.

Q. The question is, what is -- the report is called the Texas Risk Factor Report, correct? 13:30

A. Yes. 13:30

Q. So you're saying that you're relying on that report. The next question is, are there any other reports that you're relying upon in making this assertion? 13:30

A. I'm actually saying I'm relying on the Behavior Risk Factor Surveillance System data. This is one report of the data. It reflects an analysis of the data, but it's all -- this is actually -- it's reporting the information that we collect from the Behavioral Risk Factor Surveillance System. I wouldn't want to limit again -- you know, I mean, this is one report -- it's the Behavioral Risk Factor Surveillance System 13:31

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data. 13:31
Q. Well, I gather that you -- you have some 13:31
hunches that you -- that you have formed 13:31
based upon your review of the behavior risk 13:31
factor data, but I thought you said awhile 13:31
ago that you -- you've collected only this 13:31
stuff here on the table in the matter of you 13:31
getting ready to express opinions in this 13:31
case; is that right? 13:31
A. Again, could you repeat that? 13:31
Q. I say, is there anything else other than the 13:31
gray item before you that's on this table 13:31
before us within which you have located 13:31
information that supports the idea that is 13:31
expressed in this sentence? 13:31
A. Again, I would say this report reflects that 13:32
analysis that supports that statement. You 13:32
know, as we've talked about before, there may 13:32
be some other analysis like we did that again 13:32
added that document to you, the recent 13:32
Medicaid figures that we calculated on that. 13:32
It's all from the Behavior Risk Factor 13:32
Surveillance System. 13:32
Q. What do you know about the relative 13:32
prevalence of marijuana use in the 18 to 13:32

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24-year group as of 19 -- 1987 versus 1995? 13:32
A. I'm not familiar with that. 13:32
Q. Has it gone up? 13:32
A. I don't know. 13:32
Q. Has the use of alcohol among that group 13:32
increased in that time? 13:33
A. I don't -- offhand, I do not know. 13:33
Q. How about the use of street drugs, crack 13:33
cocaine, cocaine and other street drugs, 13:33
amphetamines? 13:33
A. I don't know. 13:33
Q. Is that data available in your agency? 13:33
A. Probably a better source of that data might 13:33
be from the Texas Commission on Alcohol and 13:33
Drug Abuse. 13:33
Q. Is that not collected in the BRFSS study at 13:33
all?
A. There are some alcohol questions. Substance 13:33
abuse, we don't ask that. 13:33
Q. Your next sentence here, Doctor, is you're 13:33
going to testify that although there's 13:33
limited data, the data that is available 13:33
suggests that approximately 30 percent of 13:34
adult Medicaid recipients smoke. What 13:34
limited data is there? 13:34

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A. As I mentioned, you know, we provided a recent run of the 1996 data, which was the first year to include the Medicaid question on it. 13:34
Q. Okay. 13:34
A. We did one run, and that figure was approximately 30 percent of those that reported having Medicaid as their insurance were current smokers. There's other -- I mean, we can look at education data in part. In this report there is a thing that those with less than a high school education have higher smoking rates than those with college education. Also some income information, and I think we provided some supplemental run on looking at income and those, you know, with less than $35,000 income or in the lower categories, tended to have higher smoking rates than those above $35,000 income. Whether that reflects -- again, supports and paints a picture about -- that might be applicable to the Medicaid population, again presenting some sort of consistent picture. That's the data that we have. 13:34 13:34 13:34 13:34 13:34 13:34 13:34 13:34 13:34 13:34 13:34 13:35 13:35 13:35 13:35 13:35 13:35
Q. Do you have data that specifically reports 13:35

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Medicaid recipients' use of tobacco or is it only inferences that you've drawn from such things as income levels and things such as that? 13:35

A. As I mentioned, you have in that supplemental material there was analysis of the 19 -- 1996 data that had our Medicaid data. 13:35

Q. Okay. And is that in the stuff that was given to us this morning? 13:36

A. Yes, it was. 13:36

Q. All right. And how was that -- 13:36

MR. THOMPSON: Well, actually, just to correct the record -- 13:36

MR. HLAVINKA: Sure. 13:36

MR. THOMPSON: -- it also was in the stuff given to Tom. 13:36

MR. HLAVINKA: To Tom as well? 13:36

THE WITNESS: That's right. Yeah, it was in the stuff we provided it. 13:36

MR. HLAVINKA: This was given to Tom. 13:36

THE WITNESS: Yeah. It was in that group. Yeah, I'm sorry. That was not -- that was in the original material we gave. 13:36

Q. Great. All right. And how was the 13:36

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information that's shown in that document put together? 13:36 13:36

A. It was again an analysis of the Behavior Risk Factor Surveillance System data for 1996. 13:36 13:36

Q. Of the entire population that was surveyed? 13:36

A. Yes. We, I mean, ran the analysis on the entire data set to get that figure. 13:36 13:36

Q. So you picked out every Medicaid person, and this document will reflect the number of those who reported to be smokers? 13:37 13:37 13:37

A. Right, that reported Medicaid and then weighted it to -- right. 13:37 13:37

Q. Weighted it how? 13:37

A. Based on age and gender and race. 13:37

Q. Well, are you saying that you've got Medicaid information as to how many Hispanic women on Medicaid smoke? 13:37 13:37 13:37

A. No. 13:37

Q. Well, that's gender and race, isn't it, or ethnic origin? 13:37 13:37

A. No. I was just reflecting the weighting, I mean, to -- in terms of the sample. We do weight to the Texas population based on age, gender and race -- 13:37 13:37 13:38 13:38

Q. Okay. 13:38

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A. -- to make it reportable. You understand? 13:38
Q. This reference to the adult Medicaid 13:38
recipient group, are you talking about 13:38
18-year-olds to the time they die? 13:38
A. Yes. I mean, that was -- it was data that we 13:38
collected from the BRFSS. 13:38
Q. But from that age group? 13:38
A. That's the sample that BRFSS is, is 18 and 13:38
older, so -- 13:38
Q. You recognize, don't you, that over half of 13:38
the Texas Medicaid recipients are below 14 13:38
years of age? 13:38
A. I have seen that figure. 13:38
Q. So this figure of approximately 30 percent 13:38
can in no fashion be considered to be a 13:38
surrogate for the smoking incidence across 13:38
the entire spectrum of Medicaid recipients, 13:39
can it? 13:39
A. That figure would reflect of the adult 13:39
population that are on Medicaid. 13:39
Q. Does it -- is it broken down in your report 13:39
as to the same age bracketing that you have 13:39
in the BRFSS study before you there, that is, 13:39
the 24 to 18? 13:39
A. No. 13:39

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Q. 25 to the next? 13:39
A. No. 13:39
Q. Okay. So we don't know how many of those people are over 65 and how many of them are very young? 13:39
A. No. 13:39
Q. Is there any other data source that you have from which you can determine the percentage of adult Medicaid recipients who smoke? 13:39
A. The national BRFS. 13:39
Q. Anything else? 13:39
A. There are probably some other special surveys that may have been done at other places. I don't know. I recall hearing that maybe Massachusetts had some data on Medicaid. 13:40
Q. Would you grant, Doctor, that if there are -- for example, if there were a disproportionately large number of very poor Medicaid recipients down in the Valley who are apt not to have a telephone, that the figure that you have in your report might not capture that information and might therefore reflect an inaccurate approximation of smoking incidence among Medicaid recipients as a whole? 13:40

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A. I mean, that circumstance that there may be an underestimate possibly of some of the smoking prevalence. 13:40 13:41 13:41

Q. Or there might be an overestimate if the group that's not being surveyed were perhaps comprised of Hispanic women in large number and therefore a group that doesn't smoke as much. 13:41 13:41 13:41 13:41 13:41

A. Could you repeat that? 13:41

Q. I say if the group that's not being reported or included is a group that doesn't smoke as much, like Hispanic women, then the estimate that you have here may well be an overestimate. 13:41 13:41 13:41 13:41 13:41 13:41

A. As I think I mentioned earlier, we know that there are some limitations of Behavior Risk Factor Surveillance System. It's -- we know them. We still use the data. It's very good data. I think that there are always things that we take into account as we're interpreting data. 13:41 13:41 13:41 13:41 13:41 13:41 13:41

Q. Is it peer reviewed data? 13:41

A. Could you clarify that? 13:42

Q. Well, you know, what peer review is, don't you, Doctor? 13:42 13:42

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A. Uh-huh. 13:42
Q. Is it peer review data? 13:42
A. The data itself? 13:42
Q. Uh-huh. 13:42
A. What do you mean? I mean, reports -- if there are reports submitted to a journal, then it would undergo any peer review process. 13:42
Q. Okay. But the data that you're using here, for example, in your -- the document before you, in the gray document, has that been peer reviewed by anyone? 13:42
A. There are -- this goes through certainly -- I mean, the development of a report at Texas Department of Health is looked at by various professionals and -- prior to printing. 13:43
Q. Okay. You said that you recognize that there are various deficiencies in the BRFSS data. What deficiencies do you recognize? 13:43
A. Actually, what I said was, you know, I think that we know that there are limitations to any data set, and certainly there are, you know, limitations with Behavior Risk Factor Surveillance System and we know them and, again, we still feel -- I mean, it's an 13:43

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excellent data set. 13:43
Q. Well, okay. Since you know them, will you tell us what they are? 13:43
A. I would say, you know, there is a -- I would say that telephone survey versus household survey. There are different characteristics inherent with which type of survey is conducted. There are pluses and minuses. Again, in particular with BRFS, the thought is with respect to telephone survey of tobacco use, given that the people that don't have phones tend to be the lower income, lower educated, that it's probably an underestimate of some of the tobacco prevalence. But that's one of the things that we look at in interpreting the data. But again, I think, you know, we look at some of the limitations and take them into account and still it's very useful for our planning and we think it provides us with a good picture. 13:44
Q. Have you done any kind of follow-up survey or any other kind of study to determine whether your assumption that the telephone survey will tend to miss the poorer folks and 13:44

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therefore tend to underestimate the number of smokers, that that assumption is a correct assumption? 13:44 13:45 13:45

A. This past legislative two years, there was actually a study that Texas A&M was conducting of household survey in South Texas that one of the things we wanted to look at was comparing some of the data from the household survey with our BRFS data. We have not -- they have just completed data collection on that. 13:45 13:45 13:45 13:45 13:45 13:45 13:45 13:45 13:45

Q. You know what a Colonia is, don't you? Right? 13:45 13:45

A. Uh-huh. 13:45

Q. And you know that there are literally tens of thousands of Hispanic women who live in the Colonias; isn't that right? 13:45 13:45 13:45

A. I don't know how many there are. 13:45

Q. And you know, too, don't you, that -- that even though you don't have the numbers at your fingertips, that the percentage of Hispanic women who smoke is less than the overall adult population percentage is? 13:45 13:45 13:45 13:45 13:46

A. I would say that the Hispanic female population has -- the data have shown in the 13:46 13:46

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past that it's a lower smoking rate. However, Hispanic males are actually higher. 13:46 13:46

Q. I'm talking about the women now. 13:46

A. Right. 13:46

Q. And you also don't suppose that there are too many telephones in the Colonias, don't you reckon? 13:46 13:46 13:46

A. I really don't know. I have no idea. Again, you know, I mean, we have looked at from the census data, it's approximately 8.6 percent of households in Texas don't have a phone. 13:46 13:46 13:46 13:46

Q. They don't have running water in the Colonias, do they, Doctor? 13:46 13:46

A. I don't -- I'm not sure. 13:46

Q. And they don't have sewer systems in the Colonias, do they, Doctor? 13:46 13:46

A. I don't know. I have never been to the Colonias personally. 13:47 13:47

Q. The next statement in your -- and by the way, since this is expressed in the number approximately 30 percent, whatever number you have reported in the document that we've mentioned here before, is that the number that you are happy with or can live with, or are you going to stay with approximately 30 13:47 13:47 13:47 13:47 13:47 13:47 13:47

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percent? 13:47
A. That isn't the number that was calculated 13:47
from the Behavior Risk Factor Surveillance 13:47
System. 13:47
Q. Okay. What was that number? 13:47
A. I believe 30 -- I can't recall. 30 point 13:47
something. 13:47
Q. Okay. And that's what's in this document 13:47
that we have here on the table somewhere? 13:47
A. Right, right. 13:47
Q. Okay. "Dr. Huang is expected to testify 13:47
regarding the prevalence of smoking among 13:47
teenagers." In this regard you testify that 13:47
approximately 75 percent of adults who have 13:47
regularly smoked first tried cigarettes 13:48
before their 18th birthday. In other words, 13:48
you're saying that if you -- if you're a 13:48
smoker or you've been a smoker, chances are 13:48
three in four that you tried a cigarette 13:48
before 18 years of age, right? 13:48
A. Say that again? 13:48
Q. That if one is a smoker or a former smoker, 13:48
then the chances are three in four that that 13:48
person had smoked at least to some extent 13:48
before age 18. 13:48

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A. The data -- the data reported there, yeah, that three-fourths -- and actually, there are some other data sources than national household drug survey or something that now puts it to 89 percent of current, you know, smokers started before age 18. 13:48 13:48 13:48 13:48 13:48 13:48

Q. Now, are you saying that they started to smoke before age 18 and became regular smokers before age 18, or are you saying that they first tried cigarettes before age 18? 13:49 13:49 13:49 13:49

A. I believe it's regularly smoked. And actually, let me check that resource on that to get the wording exact. 89 percent began using cigarettes and 71 percent began smoking daily by or at age 18. 13:49 13:49 13:49 13:49 13:49

Q. And what's that reported in? 13:49

A. This is from the Growing Up Tobacco Free, but it's actually reporting data from the National Household Survey on Drug Abuse from 1991. 13:49 13:49 13:50 13:50

Q. And how is that survey carried out? 13:50

A. I'm not an expert on what they've done with that. This is something that's reported in the literature. 13:50 13:50 13:50

Q. Do you even know who carried it out? 13:50

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A. National Household Survey on Drug Abuse, and I think it's -- 13:50
Q. Who is that? 13:50
A. It's reported by the Office of Smoking and Health. Actually, I would have to check on the actual operations of that. 13:50
Q. So you say as the smoking population turns 18, that what percent of them are already regular smokers? 13:50
A. It said 89 percent began using cigarettes, and 71 percent began smoking daily. 13:50
Q. Right. So 71 percent of the folks who turn 18 and are smokers -- well, strike that. 13:50
71 percent of the folks who are 18 years old and one day were smokers before they turned 18. 13:51
MR. THOMPSON: No. You got it right the first time. 13:51
THE WITNESS: What was that? Say it again. 13:51
Q. I said, 71 percent of the people who are 18 years old and one day and are smokers began smoking regularly before they turned 18. 13:51
A. 18 -- say that again. 18 and -- go ahead. 13:51
Q. 71 percent of the people who are 18 years old 13:51

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and one day and are smokers, okay, began smoking regularly before they turned 18. 13:51 13:51

A. Well, I would say that this is a report of a survey that -- you know, I think the methodology -- it was actually people between 18 and 39 or something -- or I'm sorry. You know, it's not -- I would not say -- this is the report of a survey. 13:51 13:51 13:52 13:52 13:52 13:52

Q. I'm trying to read too much into it. 13:52

A. Right. This is a report of a survey. And as even -- you know, the other figure that's there, 75 percent of adults who regularly smoke first tried cigarettes before their 18th birthday and half became regular smokers by age 18, that was actually another survey. 13:52 13:52 13:52 13:52 13:52 13:52 13:52

Q. And what survey was that? 13:52

A. I believe it was unpublished data from National Institute of Drug Abuse. 13:52 13:52

Q. And who is the -- who puts that information together? What's the organization that sponsors it? 13:52 13:52 13:52

A. National Institute of Drug Abuse or NIDA. I believe that's where that figure came from. 13:52 13:52

Q. Is that an outfit sponsored by the American Cancer Society or by the NIH, or who sponsors 13:53 13:53

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that group? 13:53
A. That's the federal. 13:53
Q. Federal government? 13:53
A. Right. 13:53
Q. Do you know anything about how that survey 13:53
was conducted or carried out? 13:53
A. Again, I wasn't involved in that. It's a 13:53
report of a survey. But again, these are 13:53
survey results. They paint a picture. That 13:53
was the results that came out of that to say 13:53
that someone 18 and one day -- again, it's a 13:53
reporting result. It's painting a picture. 13:53
I can't tell you on a given day how many 13:53
percentage have started. 13:53
Q. Do you have any idea how many people were 13:53
surveyed in either of those surveys? 13:53
A. I would have to look that up. 13:53
Q. Well, you aren't going to rely upon a survey 13:53
unless you have some idea how much -- how 13:53
valid it is, will you? 13:53
A. Repeat that. 13:53
Q. I mean, some surveys are more valid than 13:54
others, are they not? Right? 13:54
A. I would say -- I mean, my understanding is -- 13:54
I mean, these are accepted data that have 13:54

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been published that are put out by the federal government on the results of their survey. And again, I can tell you -- 13:54

Q. Do you have any idea of the methodology used by -- in either of those two surveys? 13:54

A. Again, I was not involved at all in collection of that. I have read some of the things of the methodology. I don't recall right now the details of it. 13:54

Q. So without knowing anything about the methodology, you can't tell us whether it's really a reliable survey or not, except for the fact that you say it's sponsored by the federal government, so it must be reliable. Is that your -- the basis for your reliance? 13:54

A. No, I did not say that. 13:55

Q. I mean, is there some other information that you have that tells us that -- or tells you that this is a reliable pair of surveys? 13:55

A. When I've looked at it in the past, I think -- I think it -- again, I can't describe to you the exact methodology now. When I've looked at it in the past, I felt that it was -- you know, the methodology seemed sound and that these are probably 13:55

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well-conducted surveys, but I cannot tell you right now the specific methodology that was performed.

Q. Does the -- I have these numbers here for -- again for 1992-93 from the BRFSS survey that breaks down the cigarette smoking by adults agewise as follows. 18 to 24, 20.8 percent. 25 to 44, 25.9 percent.

A. What year was that?

Q. '92 to '93 is the -- is the breakdown that I have here. 18 to 24, 20.8 percent. 25 to 44, 25.9 percent. 45 to 64, 25.6 percent, and 65 plus, 12.6 percent. Does that kind of trend -- is that kind of trend shown in the data that you have for the years that you looked at, that is, that there are more smokers in the 25 to 44-age bracket than there are in the 18 to 24-year bracket, and that the number remains about the same in the 45 to 64 bracket as is the case in the 25 to 44 bracket?

A. In this report, we reported that the 35 to 44-year-old age group had the highest percentage of smokers.

Q. Okay.

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A. And that it did -- it was lower on either side of that. 13:57
Q. Okay. So is there a trend up to that peak and then a trend back down from that peak? 13:57
A. In terms of the age distribution, again, the 35 to 44-year-old age group had the highest percentage. 13:57
Q. Okay. 13:57
MR. THOMPSON: Can we take a short break? 13:57
MR. HLAVINKA: You bet. 13:57
THE VIDEOGRAPHER: Going off the record at 1:57 p.m. 13:57
(RECESS) 14:06
THE VIDEOGRAPHER: We're back on the record at 2:06 p.m. 14:06
Q. Doctor, did you say awhile ago that you had figures on the Hispanic men percentage wise who smoke? 14:07
A. I know that that has been looked -- looked at. It's not in this report. 14:07
Q. Yeah. I thought that you gave us a value awhile ago. 14:07
A. I didn't -- no, I did not give a figure. 14:07
Q. I have here a document published by the U.S. 14:07

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Department of Health and Human Services, the CDC, regarding Texas in 1996, and it reports the smoking -- smoking in selected demographic groups in Texas versus the BF -- BRFSS median -- the national median for 1994, and the --

MR. THOMPSON: Do you want to mark it as an exhibit?

MR. HLAVINKA; I'll mark it, yes.

Q. The -- we'll call it Exhibit Number 6. The chart shown in Exhibit Number 6 indicates that Hispanic smoking prevalence in Texas is about 15 percent. Is that your -- as far as you're concerned, a correct figure?

A. Okay. Could I see that, please?

Q. Sure.

A. Our data for BRFSS for 1994, we have a figure of 15 percent for Hispanics.

Q. All right. But that's not broken down gender wise?

A. No, no.

Q. All right. You recognize, though, that the women smoke less than the guys?

A. We have data, I know, and there have been reports, yeah, that I believe, yeah, Hispanic

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women have lower smoking rates than Hispanic men. 14:08

Q. And I have here in this same report, and tell me if it comports with what you have in your report, that the -- among the black population in Texas, it looks to be perhaps somewhere between 21 and 22 percent. Is that what you have? 14:08 14:08 14:09 14:09 14:09 14:09

A. For 1994? 14:09

Q. Yes, sir. 14:09

A. We have 20.8 percent. 14:09

Q. 20.8. Okay. 14:09

(Deposition Exhibit No. 6 14:09
(marked for identification.

Q. I also have something here that I will divert to very briefly that came from the -- looks like www.tdh.state.tex.us.programs.snd&pat underline programs slash NTN. Sounds like something that comes from your agency that purports to report that in the Texas population overall, the rate of death from cardiovascular disease is 193.2 among the population overall versus in the U.S. where it's 180.4 in 100,000. And yet, I think we established a while ago that the smoking 14:09 14:09 14:09 14:09 14:09 14:10 14:10 14:10 14:10 14:10

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rates in the U.S. and in Texas are about the same. What accounts for the increased heart disease death rate that we have in Texas over the national population? 14:10

A. Could I see that, please? 14:10

Q. Sure. 14:10

MR. THOMPSON: Since we're referring to it on the record, could we also mark that? 14:11

MR. HLAVINKA: Sure, you bet. 14:11

MR. THOMPSON: Thank you.

A. I'd actually want to look at this a little more. 14:11

Q. Sure. 14:11

A. Because -- yeah. To interpret it properly, I'd want to look at it again. 14:12

Q. But you'd have to assume, do you not, that there are things operating other than smoking in those -- in those Texans that are in the excess group, would you not? 14:12

A. I would say -- I mean, I agree that there are other factors involved in cardiovascular disease mortality. 14:12

MR. HLAVINKA: Okay. Let's mark that Exhibit 7 for the record, please.

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(Deposition Exhibit No. 7 (marked for identification.

Q. I'll move to something else. I think you're going to testify also, according to your statement, that approximately 30 percent of Texas high school seniors are smokers; is that correct?

A. The figures from the Texas Commission on Alcohol and Drug Abuse survey, I think, 1996 that's right there (indicating), seniors, I believe, was about 33 percent.

Q. I just saw it a minute ago.

MR. THOMPSON: I know you're looking for it, and I --

MR. HLAVINKA: I'm looking for the '94 edition. Do you have that?

THE WITNESS: Fact sheet?

MR. THOMPSON: It was right here. Here's '92. What year are you looking for?

THE WITNESS: Here's '96.

MR. THOMPSON: '94?

MR. HLAVINKA: I had one that was --

MR. THOMPSON: That was the one sitting on top.

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Q. Good, good. All right. This is '92, yes. 14:13
Your '96 figures are how much? 14:13
A. For past month tobacco use, 33.6. 14:13
Q. And what kind of survey is that based upon? 14:13
A. That's a school survey. 14:13
Q. Do you know anything about how that survey is carried out? 14:13
A. Again, I was not involved in conducting it. I know they have a very large sample, and it's conducted in the schools. 14:13
Q. Do you know how large the sample is? 14:13
A. Let me see. 106,924. 14:14
Q. Students? 14:14
A. Yes. 14:14
Q. Do you know how many students there are in Texas? 14:14
A. No, I don't. 14:14
Q. Don't you know that there are over 30 million? 14:14
A. I didn't know the number, no. 14:14
Q. Do you know which school districts? 14:14
A. These are actually for 7th through 12th graders. 14:14
Q. Right. So you don't know how many seniors there are in that group of 106,000, do you? 14:14

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A. 13,625. 14:14
Q. Okay. Do you know how many school districts within the State of Texas are involved in the study? 14:14
A. No, I do not. 14:14
Q. Back in -- 14:14
A. Again, I do not conduct the study. I've been in contact with the people at TCADA. You know, we have worked with them on various projects. We rely on this data. We think it is useful, reflects -- reflects the information that they are -- we are looking for and we use it. 14:15
Q. You recognize, don't you, that it would be important to know whether or not the school districts that are involved in the survey fairly represent the population of the state? Isn't that -- isn't that a truism? 14:15
A. Sure. 14:15
Q. And -- but you don't know that in this case, do you? 14:15
A. Well, again, I would -- you know, I do not claim to have been involved in the survey design. It is something that we generally consider as being a valid survey that we use, 14:15

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and as with all other surveys and things, there are limitations, but we utilize this data and there are others that could more -- better describe the methodology of what they're -- they did to conduct the survey. 14:16

Q. What do you base your opinion as to the survey's validity upon, if you don't know anything about how it's done? 14:16

A. Again, I know that it's a school survey. I have in the past looked at some of the methodology and sample that they had and I felt comfortable with it when I looked at it in the past. I do not recall the details of the conduct of the survey, and I don't claim to have that expertise and details of what they have. 14:16

Q. I haven't had occasion to -- I haven't had a chance to look at all this for sure, but I just glanced at the preface in this 1992 survey and it says that the survey has been ongoing since 1988; is that correct? 14:17

A. Yes, I believe so. 14:17

Q. And it says that in that time between '88 and '92, that close to half -- close to half of the school districts in the state had been 14:17

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involved in the survey. We don't know how many may have been involved in any one year, though, do we? 14:17

A. That information I'm sure is available. 14:17

Q. But you don't know what it is? 14:17

A. I don't -- I do know -- I mean, you do not have to include every school district in the state to have a valid survey. 14:17

Q. But you have to have a representative sample, do you not? 14:17

A. Right. And again, I don't claim expertise. I do recall that they did a sampling of school districts and -- 14:17

Q. Do you remember where you got that from? 14:17

A. Some of the reports that had some of the methodology. And again, it's been a while since I've looked at it. 14:17

Q. Something published in a document such as 1992 Texas School Survey of Substance Abuse? 14:17

A. Quite possibly so, yes. 14:18

Q. Do you know of anything else that you've seen that has described the methodology used in conducting the survey? 14:18

A. I think probably the full reports there, what I've seen in the past. 14:18

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Q. Well, in 1992, the substance abuse survey report reported that the number of seniors who smoke in Texas is 24 percent. Are you saying that there was a jump from 24 percent to the number that you had, 29 percent, in -- in those years, or are you -- do you ascribe that to a quirk in the survey methodology? 14:18
A. Could you repeat that, please? 14:18
Q. In 1992, the percentage of seniors who this -- who are reported by this survey to have been smokers was 24 percent in Texas, and I think you've just said that you've found something in the '96 numbers that are greater than that, right? 14:18 14:19
A. Right. 14:19
Q. Okay. And up to the level of what, 29 percent, was it? 14:19 14:19
A. The figure for 1996 for 12th graders was 33.6 percent. 14:19 14:19
Q. 33 percent. Okay. 14:19
A. And, actually, I mean we have a fact sheet that we do say there has been -- I mean, we consider that there has been an increase, and it's generally been accepted that there is -- has been an increase in youth smoking rates. 14:19 14:19 14:19 14:19

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Q. Been accepted by who? By you or -- 14:19
A. In our office, we, and personally I think 14:19
feel that there has been an increase in youth 14:19
smoking. 14:19
Q. And that's without knowing anything about how 14:19
the surveys from which these numbers are 14:19
derived are conducted? 14:19
A. Well, again, I would say I'm not an expert in 14:19
the conduct -- conduct of the survey. I have 14:19
looked at it in the past. It's information 14:19
that we use. I cannot go through the 14:20
methodology of this particular survey. We 14:20
are in contact with the people at TCADA that 14:20
conduct the survey. We've been involved with 14:20
them, and I think that, again, it's 14:20
information that we use and rely on and as do 14:20
others. 14:20
Q. What role does the State's inaction in the 14:20
matter of youth smoking play in any increase 14:20
in incidence of youth smoking? 14:20
A. Could you repeat that, please? 14:20
Q. What role does the State's inaction in the 14:20
matter of discouraging smoking among youth 14:20
play in any increase, if there has been one, 14:20
in the incidence of smoking among youth? 14:20

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A. I guess, first of all, I would disagree with in terms of any statement of inaction. I think that the Health Department, other state entities, have certainly been involved and have been working on tobacco control and efforts to reduce youth smoking rates over the years, so --

Q. Okay. This 1992 substance survey also reports about the number of marijuana users there are among Texas seniors. Does your 1996 data reflect that?

A. There's a figure here for 1996 grade 12 that 18-and-a-half percent of 12th graders are --

Q. Do you see back in 1992 it was eight percent by these numbers? What accounts for that increase?

A. I couldn't respond.

Q. What do you ascribe the increase in youth smoking -- youth cigarette smoking to -- that you've observed in these numbers in comparing the '92 number with the '96 number?

A. My own beliefs on that. I mean, I certainly think that there continue to be increased marketing efforts to youth. Again, get, you know, to some of the studies that we talked

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about earlier -- the study I talked about earlier. I mean, I think, you know, that the Joe Camel campaign, that there's been nationally up to $6 billion a year spent on advertising and promotion of tobacco products. 14:22

Q. Is there something like -- excuse me. Is there something like Joe Camel in the marijuana market? 14:22

A. There isn't. I mean, in terms -- I mean -- 14:22

MR. THOMPSON: Please let him finish. 14:23

Q. Any phenomenon such as that, yes. 14:23

A. Again, I would say the marijuana market, I mean, there is not advertising for marijuana products, at least in publications I know. 14:23

Q. So there's nothing like Joe Camel in marijuana, is there? 14:23

A. I would say -- I mean, again, my own feelings, I know that there have been implications of certainly tobacco is a gateway drug even, and my thoughts there, you know, certainly could be something following if there's increasing in tobacco use. 14:23

Q. So you think that Joe Camel has caused the 14:23

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number of marijuana smokers to more than double in less than four years? 14:24
A. No, I'm not saying that -- no, I would not. 14:24
Q. What is the number of -- the percentage of high school seniors that are said in the 1996 BRFSS report to have drunk alcohol? 14:24
A. 50.8 percent. 14:24
Q. That's been pretty steady then over the years. How about those who have used cocaine? 14:24
MR. THOMPSON: Just to correct, you said the BRFSS report, and you're questioning him about the TCADA report. 14:24
Q. The report that you have before you, right? The TCADA report, right. And how about the rate of cocaine use as reflected in that TCADA report for '96? 14:24
A. For 1996 on this report, it's seniors were 3.4 percent. 14:24
Q. That's going up from 2 percent in '92. Is there some phenomenon -- phenomenon in our society that accounts for those increases other than tobacco advertising, as far as you're concerned? 14:25
A. You're asking for my -- 14:25

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Q. Sure.
A. -- personal view on that. 14:25
Q. Right. 14:25
A. Let me think a little. 14:25
Q. That's one of your concerns in the public 14:25
health area, isn't it, things such as cocaine 14:25
use, marijuana use, along with tobacco use? 14:25
A. Well, specifically, the Health Department 14:25
does not deal with the cocaine and -- I mean, 14:26
there is Texas Commission on Alcohol and Drug 14:26
Abuse specifically deals with those 14:26
substances. 14:26
Q. Okay. 14:26
A. I would say that there are other factors. 14:26
Q. Factors such as? 14:26
A. Personally -- I mean, you know, my own 14:26
feelings on it, that I'm sure there are other 14:26
factors and I think one of the factors is 14:26
that the heavy marketing that goes into it. 14:26
Again, $6 billion a year is a lot of 14:26
marketing. 14:26
Q. But I'm talking about the marijuana and the 14:26
cocaine. 14:26
A. Oh, I'm sorry. You're asking about -- I 14:26
can't speculate on that. 14:26

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Q. Okay. Do you think there's been an overall loosening of societal mores over the years? 14:26
A. I couldn't speculate on that. 14:26
Q. You haven't observed that? 14:26
A. No. 14:26
Q. Do you think there's been -- do you think that peer pressure plays any part in youngsters using marijuana or using cocaine? 14:26
A. In using marijuana and cocaine? 14:27
Q. Uh-huh. 14:27
A. Again, I'm not -- that's not my area of expertise. 14:27
Q. Do you think that peer pressure plays any part in youngsters using tobacco? 14:27
A. I think that peer pressure is one of the components that affects the smoking rate, but I think you have to look at what creates peer pressure also in terms of societal messages, images, things like that. So again, I think that there are several factors. 14:27
Q. If peer pressure is involved in the increase in the prevalence of the use of marijuana, what society -- what societal mechanisms are fueling that peer pressure? 14:27
A. Again, I really can't address the marijuana 14:27

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issue. 14:27
Q. Doctor, there's a quirk in these numbers that 14:28
I don't quite understand, and that is that 14:28
you say that what, 33 percent of high school 14:28
seniors smoke in '96? 14:28
A. There is actually a discrepancy on this 14:28
particular chart. We had 33.6 percent, yes, 14:28
on that. I'm not sure why there's a 14:28
discrepancy between these figures. 14:28
Q. What do you have in the other reports? 14:28
A. 31 percent. 14:28
Q. Accepting either one of those numbers, the 14:28
data is to the effect, isn't it, that once 14:28
you get into the 18 to 24-age bracket, that 14:28
the smoking rate is about 20 or 21 percent; 14:28
isn't that correct? That's what BRFSS 14:28
reports; isn't that right? 14:28
A. Right. Well, I would say again for 1996, we 14:29
had 22.9 percent, so it's almost 23 percent 14:29
among 18 to 24-year-olds. 14:29
Q. Did all those kids stop smoking after they 14:29
finished high school, or what happened to 14:29
these 33 percent who all of a sudden dropped 14:29
down to 22 percent? 14:29
A. I mean, I can't answer what happened. 14:29

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Q. Does that tell you that the -- that perhaps the -- that one or these two -- one of these two studies is not valid? One of them -- one of them at least, if not both, are inaccurate? 14:29
A. I don't -- I would not agree with that statement. I don't think that that's -- 14:29
Q. How do you reconcile those numbers? If you can't say they quit smoking, how do you reconcile the numbers reported on the one hand by -- by the BRFSS data in reference to 18 to 24-year-olds versus the high school senior data reported by TCADA's survey -- school survey? 14:29
A. Well, I mean, I think this is an age -- there's an age group here, 18 to 24, that that figure from BRFSS reflects, and this is for just 12th graders, so they're not the same -- they're not claiming to be a number -- a figure for the same population. 14:30
Q. Right. There's a difference in the age group, but one is juxtaposed to the other, isn't it, 18-year-old on the one hand and the high school seniors on the other hand? They're right up against each other, and the 14:30

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ones that are over 18, presumably out of school by now, those -- their smoking rate has dropped down to 22 percent. How do you reconcile that? Do you think they just all quit in that -- in that time frame, or do you think that there's something wrong with the numbers? 14:30

A. I think -- I mean, I think if you again compared the 18 to 24-year-olds with the 25 to 34-year-olds, I mean there are differences in those figures. We've talked about between 35 and 44 there's a peak. You know, I mean, if you were to go along that logic, everyone would be at exactly -- it would be a straight line for everyone to be smoking. 14:30 14:31 14:31 14:31 14:31

Q. Quite the contrary. If the 25 to 44-year-old group has a rate of 25.9 or 26 percent, which is the number I have for this '92 -- that is, if it's higher than the rate among the next lower age bracket, then it's very likely that the ones in the lower age bracket who were approaching the upper end of that age bracket smoke more percentage wise than those who are at the lower end of the bracket, right? 14:31 14:31 14:31 14:31 14:31 14:31 14:31

A. Say that again. 14:31

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Q. I said, it's likely, is it not, that the ones who are toward the upper end of the lower age bracket smoke more than the ones who are at the lower end of that lower age bracket. 14:31 14:31 14:32 14:32

A. In the 18 to 24-year-old group you're talking about? 14:32 14:32

Q. Yeah. Right. When you look at the 25 to 44-year-old group, because they smoke a good bit more on the average, right? 14:32 14:32 14:32

A. Uh-huh. 14:32

Q. So chances are that the 18-year-olds in this 18-year-old report in the BRFSS number, those 18-year-olds smoke even less than the 22 percent that you have reported in your report. That is, the trend is up, is it not, from the time they -- they start being surveyed? 14:32 14:32 14:32 14:32 14:32 14:32 14:32

A. Well, actually, one other thing is -- (indicating). They're not exactly the same question either, I mean, in terms of continuity. This is past month use versus BRFSS's current use. 14:33 14:33 14:33 14:33

Q. Okay. 14:33

A. So it is not -- you can't make that jump between the two. 14:33 14:33

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Q. You're saying there's likely to be more who smoked in the past month than there are who are current users? 14:33
A. Correct. 14:33
Q. Both questions are somewhat vague, aren't they? 14:33
A. No, they're differently worded. I would say they're differently worded. I mean, I think that respondents can understand the distinction that -- 14:33
Q. Well, then, it's incorrect to say, then, that 30 percent of high school seniors are smokers. What you want to say is that according to the TCADA survey that you're relying upon, 30 percent of high school seniors or 32 percent, whatever the number was, have smoked within the last month. 14:34
A. That would probably be a more specific -- 14:34
Q. Right. Whether they've had one cigarette or a dozen -- 14:34
A. Right, if you define that past month as being a smoker, then, right. 14:34
Q. Now, there's nothing in the TCADA survey that has to do with Medicaid recipients or not, is there? 14:34

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A. To my knowledge, there isn't, yeah. 14:34
Q. Paragraph 4, "Dr. Huang is expected to testify that although the tobacco industry has long claimed that it does not target children and adolescents, cigarette advertising clearly both appeals to this segment of the population and is presented in a manner that is readily accessible to this age group." I think I understand what you're saying here, but can you tell me what data sources you're basing that upon? 14:34 14:34 14:34 14:34 14:34 14:34 14:34 14:34 14:35 14:35
A. That particular statement comes from that study that I conducted previously, and one of the questions was of the students, when was -- did you last -- I think the exact wording was something like did you last see a cigarette advertisement today -- when was the last time you saw a cigarette advertisement, today or in the past week. And as I recall, you know, like 35 or 36 percent of students had seen -- recalled seeing a tobacco advertisement that day, and 85 or 86 percent had recalled seeing it in the past week. 14:35 14:35 14:35 14:35 14:35 14:35 14:35 14:35 14:35 14:35 14:35
Q. Okay. Do you recall whether you asked them where or in what format they may have seen 14:35 14:35

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advertising? 14:35
A. No, I did not ask them. 14:35
Q. All right. So then what do you base your 14:35
statement upon that it's presented in a 14:35
manner that's readily accessible to this age 14:36
group? Are you -- are you saying by this 14:36
that it's specifically targeted to that age 14:36
group or just that they can see it, too? 14:36
A. That they can -- I would say, again, I mean, 14:36
some of the advertisements that we selected 14:36
for this study, I mean, they were taken from 14:36
magazines that certainly the kids were 14:36
exposed to, Rolling Stone, things like that, 14:36
Spin, that they are exposed to. Again, I 14:36
couldn't get at intention. I was just 14:36
reporting what the kids reported and that's 14:36
why, again, I think, you know, there's 14:36
interest in what would be in some of the 14:36
internal documents in terms of getting at 14:36
intention and making some link like that. 14:36
Q. Sure. And when you say it clearly appeals to 14:36
this segment, what aspect of the advertising 14:36
that you studied was it that specifically in 14:36
your view appealed to the segment of the 14:37
youth? 14:37

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A. We asked -- its actually likability. 14:37
Q. I'm sorry? 14:37
A. Likability. And the wording in that was "How much do you" -- "How much do you like this advertisement?" 14:37
Q. Right.
A. And there were, you know, some -- I know that in the advertising literature, something, there are some correlations with likability. The appeal of advertisements or likability is a market research measure which has been shown to be strongly related to affect on sales. 14:37
Q. And was it the Joe Camel ad that you were asking about or something else? 14:37
A. All of the cigarette advertisements that were in the study, we asked about their likability or how much they liked the ad. 14:38
Q. And how did you -- I mean, how were they asked to rate the likability? Like it a lot or think it's lousy, or what was the scale of response that they were called upon to give? 14:38
A. It was like, I think, a five-point scale. I don't remember the exact words they were using. I could get that for you. Hold on. 14:38

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Let me see -- yeah, I could -- it was a five-point scale. 14:38

Q. I see where, for example, you asked them, "How much do the models seem like this," and then you would itemize characteristics that are shown on -- 14:38

A. Yeah, there are 19 attributes, one of those charts. 14:38

Q. On one of these, where it says, "Athletic, good looking, kind, slim, macho, smart, sexy"? 14:38

A. Right. 14:39

Q. Okay. And they were asked to respond one to five? 14:39

A. Right. 14:39

Q. And is the hard data reported in that journal article which you have there the data that you retrieved from your study? 14:39

A. Yes. There are tables with some of the results. 14:39

Q. How did you select what you included in that article? As far as the total universe of information that you gathered, what part of it did you put in there and what part did you leave out and by what criteria did you make 14:39

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that election? 14:39
A. Okay. Can you clarify that? 14:39
Q. Well, certainly you must have collected some 14:39
information that you do not include in the 14:39
journal article that you have there before 14:40
you. 14:40
A. Okay. I don't -- I don't even remember 14:40
specifically -- 14:40
Q. All right.
A. This was several years ago. 14:40
Q. Do you have any other basis for your opinion 14:40
here that cigarette advertising clearly 14:40
appeals to the adolescents and target 14:40
audience? 14:40
A. I think -- I mean, there are certainly other 14:40
studies that have been done on this, but what 14:40
I'm really looking at with this is the study 14:40
that I conducted. 14:40
Q. If you have seen other studies that report 14:40
this, I take it that you can't name them for 14:40
me here now or identify them in any fashion 14:40
for me here now. 14:40
A. There might be some articles that were 14:40
included in the information that we provided 14:40
that -- you know, I mean, there's the MMWR 14:41

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which looked at the three most heavily advertised brands were the three highest brand usage among kids, things like that. 14:41

Q. MMWR stands for what? 14:41

A. Morbidity and Mortality Weekly Report. 14:41

Q. And that's in this material here before us? 14:41

A. Yes. 14:41

Q. And how does the usage of various brands among adolescents and children, how is that information gathered? 14:41

A. In that particular article? 14:41

Q. If there is a particular article, yes. 14:41

A. I'd have to look at the methodology. 14:41

Q. Is there anything other than the MMWR information that might support your opinion that -- that the advertising clearly appeals to adolescents and children? 14:41

A. I mean, there have been articles -- you know, some other articles looking at Joe Camel's appeal. 14:42

Q. Have you had any specific work in your education and training in the areas of marketing or psychology, Doctor? 14:42

A. I do not claim to be a psychologist. I mean, I have had certainly some psychology courses 14:42

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during my training. 14:42
Q. Is there some aspect of your training in psychology that you're applying in formulating this opinion that cigarette advertising appeals to children and adolescents? 14:42
A. Again, I think the main basis for this is the study reporting the results that we found on this particular study. 14:42
Q. Good. You also said that -- in your report that you will testify that children and adolescents are both exposed to and well aware of cigarette advertising products. Is that also based upon your survey? 14:43
A. Right. 14:43
Q. Anything else come to mind that you base that upon? 14:43
A. That was the main thing. 14:43
Q. Also testify that smoking initiation occurs at age nine, increases rapidly after 11 to 18 years and peaks at 17 to 19 years of age. And what is that based upon? 14:43
A. That was a reference in that article. 14:43
Q. In your article? 14:43
A. Yes, uh-huh. A study that had been done. 14:43

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There are other studies that look at some of the initiation of youth smoking. 14:43

Q. Okay. So you're saying that that article is referenced in your "Black/White Differences in Appeal of Cigarette Advertisement" article? 14:43

A. That particular figure, yes, is referenced, and I think also, you know, some of the other supplemental materials talk about the age of initiation. 14:44

Q. Have you read the journal articles that are -- that you reference in your article and that report that number? 14:44

A. Yes, I have. 14:44

Q. Is there more than one or just one? 14:44

A. That was the main one that was specifically referenced in that article. 14:44

Q. Okay. And do you know anything about how that gentleman or group of gentlemen or ladies and gentlemen came up with those numbers? 14:44

A. I don't recall. Again, it was several years ago. 14:44

Q. But ordinarily, the article will report the methodology, will it not? 14:44

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A. Right, right. 14:44
Q. So beyond what's reported in the article as being the method used, you wouldn't know anything about how it was done, right? 14:44 14:44 14:45
A. Right. Actually, I mean, I've communicated with one of the authors of it in the past. 14:45 14:45
Q. And who was the author that you communicated? 14:45
A. I think Luis Escobado was one of them. 14:45
Q. Where is he from? 14:45
A. He was in the Office of Smoking and Health, CDC. 14:45 14:45
Q. CDC? Do you know what segment of the population that they surveyed? 14:45 14:45
A. Again, I don't recall. This was several years ago. 14:45 14:45
Q. Do you know whether it was a national survey or Texas survey or a Baltimore survey, or where was it? 14:45 14:45 14:45
A. I don't recall. 14:45
Q. Now, can you -- now that we've gone through your report, Doctor, can you think of any other opinions that you will be offering at the trial than those that are expressed in your report and which we've generally discussed here today? 14:46 14:46 14:46 14:46 14:46

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A. Nothing that, as I mentioned earlier, except for, you know, I'm asked an opinion on something perhaps. I don't know how that works, but -- 14:46
Q. But you've been asked -- you haven't been asked to go beyond what you've done to this point, I take it. 14:46
A. No. 14:46
Q. Do you have an opinion within a reasonable degree of medical certainty that any specific -- that any identifiable specific Medicaid recipient has suffered any identifiable adverse health effect by virtue of cigarette smoking? 14:47
A. As we mentioned earlier, I have not looked at any medical chart of any Medicaid recipient. 14:47
Q. Do you have an opinion with a reasonable degree of medical certainty on the background risk for cardiovascular disease without regard to smoking? 14:47
A. Say that again. 14:47
Q. Do you have an opinion as to the background risk for the development of cardiovascular disease without regard to smoking? 14:47
A. I'm still not quite sure what you're saying. 14:47

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Could you clarify that? 14:47
Q. There is a background risk of getting heart disease whether a person smokes or not, right? 14:47
A. Right. I mean, you know, there are other factors. 14:48
Q. And do you know how many people -- how many nonsmokers among the 100,000 will develop heart disease? 14:48
A. I don't have -- I don't have a figure that I could give you right now. 14:48
Q. And do you know how many smokers among 100,000 -- how many smokers among 100,000 will develop heart disease? 14:48
A. Smokers or nonsmokers? 14:48
Q. Smokers now. 14:48
A. I can't give you a figure. 14:48
Q. So you don't know how many nonsmokers will develop heart disease and you don't know how many smokers will develop heart disease? 14:48
A. There are data that have gone into, you know, coming up with some of the attributable risk factors. I cannot -- I don't know it off the top of my head. 14:48
Q. All right. So you don't want to address that 14:48

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and you won't address those matters upon your trial testimony, I take it. 14:48 14:49

A. Correct. 14:49

Q. Okay. You used the word "cause" awhile ago in our testimony -- in our discussion. How do you define that word as you use it in your jargon? 14:49 14:49 14:49 14:49

A. Well, I would say -- I mean, when I used the term "cause" earlier, is there enough evidence to say that tobacco use caused, say, lung cancer. And I feel that the number of epidemiologic studies that have shown that association, the consistency of those studies, some of the other factors in terms of looking at dose response, all support what would be considered -- that you could make a statement that tobacco use causes -- 14:49 14:49 14:49 14:49 14:49 14:49 14:49 14:49 14:49 14:49 14:49

Q. I think you've just sort of gone in a circle there, Doctor, if you'll -- if you'll pardon me. I'm asking you to tell me what you mean when you say that something causes something else. When you use the word "cause," do you mean to say that it is something that might have been involved in the development of or something that is a necessary mandatory 14:50 14:50 14:50 14:50 14:50 14:50 14:50 14:50 14:50 14:50 14:50

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antecedent to the development of? What do you mean when you say "cause"? 14:50
A. I think that there are people who have lung cancer that would not have developed that lung cancer had they not smoked. 14:50
Q. Right. But that still -- if you can, just define that word for me, the word "cause" as you use it. 14:51
A. Again, I mean, that would probably be my best definition in that situation. 14:51
Q. And so you define the word "cause" by saying that some people have lung cancer because they smoke? 14:51
MR. THOMPSON: That's not what he said. 14:51
Q. Can you flesh it out a little for me so I can understand what you're trying to say when you use the word "cause"? 14:51
A. I find cause to be pretty self-evident. 14:51
Q. Well, if you can't define it for me, you must not have much of a notion what it means, so it must not be very evident. When you say that something follows temporally, is that sufficient in your mind to a make a causal connection? 14:51

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A. No.
Q. Okay. What more does it take than that?
A. Again, I mean, I'd almost go back to -- with this situation they would not have developed that lung cancer but for the fact that they smoked.
Q. In other words, it's a necessary antecedent to the development of that condition.
A. No, I mean, I would not say that that is -- I would say in that particular situation -- and I'm not a linguist, you know, in terms of --
Q. The reason I'm asking that is, you know, there's this notion of risk factor that I think we've bandied about as well, and risk factor is something different than a cause, isn't it?
A. A risk factor -- correct.
Q. Because in any given case --
A. A risk factor is not a cause.
Q. Right, because in any given case, a risk factor might or might not really be playing a part. You know, if my dad had died at age 45 from heart disease and if I survive to age 90, chances are the risk factor of my dad's having died at age 45 just didn't work in my

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case, right?
A. I'm sorry. Say that again.
Q. I'm just using that as an example of how risk factors don't always operate to bring about something. Isn't that what a risk factor is? It's something that can be associated with some outcome, but doesn't necessarily operate to produce that outcome?
A. I would say that, I mean, risk factors are -- there are some factors that can put people at greater risk for an outcome. There are certainly some risk factors that can cause an outcome.
Q. Okay. I can see how if I were to put my hand under a falling hammer, that my putting my hand there would be a risk factor that caused that outcome. But in the field of public health, there's nothing quite that black and white, is there, as far as the risk factors are concerned? What risk factor is there that you say is synonymous with a causal factor?
A. As we mentioned earlier, they're not -- there -- there's differences.
Q. They're different, sure.

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THE WITNESS: Do you mind if we take a break for a second? 14:55

MR. HLAVINKA: Sure, you bet. 14:55

THE VIDEOGRAPHER: We're going off the record at 2:54 p.m. 14:55

(RECESS) 14:55

(Deposition Exhibits Nos. 8-11 (marked for identification 15:03

THE VIDEOGRAPHER: We're back on the record at 3:04 p.m. Tape No. 3. 15:04

Q. Doctor, I have an excerpt here from a document called, "Medicaid, Where Does It Hurt" put out by Comptroller Sharp's office back in '93, and it's labeled as Exhibit Number 8. And the statement is made in this report that children are by far the largest group of Medicaid recipients in Texas, that in '92 that made up 54 percent of 1.1 million of Texas Medicaid recipients. Does that comport with your understanding? 15:04 15:05 15:05 15:05 15:05 15:05 15:05 15:05 15:05

A. Again, I have seen that figure. I am not a Medicaid expert, and -- 15:05 15:05

Q. And it -- it continues by saying that half of Texas Medicaid children are Hispanic and most are younger than 10 years of age. Does that 15:05 15:05 15:05

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also comport with your understanding of the Medicaid population? 15:05
A. Actually, I don't know that I've seen that level of detail, so I don't know. 15:05
Q. You'd grant, wouldn't you, that most of those kids under age -- under age 10 don't smoke? 15:05
A. I don't know. 15:06
Q. It would be a rarity among those, would it not? 15:06
A. I couldn't speculate. I have no data on that. I would think that they don't smoke. 15:06
Q. And certainly if 54 percent of all Texas Medicaid recipients are children, then insofar as that group is concerned, the adult smoking figures are meaningless. Is that fair? 15:06
A. Again, this is a scenario -- you know, I mean, I'm really not familiar -- truly not familiar with Medicaid. I don't work with Medicaid very directly and -- 15:06
Q. What impact on the health care costs of children would the adult smoking population exert? 15:07
A. Again, I'm not an expert on it. There are certainly some perinatal things associated 15:07

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with maternal smoking, and, you know, certainly low birth weight, SIDS, asthma among kids, you know, passive smoking. There are certainly things that smoking affects children, but again, I'm not -- 15:07

Q. All right. The item also says that -- that 75 percent of elderly Medicaid recipients are women. Does that comport with your understanding of the Medicaid population and of the elderly population? 15:07

A. I don't know. 15:07

Q. Okay. It goes on to say that nearly 75 percent of Medicaid nursing home residents are Anglo women, and 42 percent are over 85 years of age. Do you have anything to either support or contradict that information? 15:08

A. I -- I can't address that. 15:08

Q. You'd grant, would you not, that a smaller proportion of women in that age bracket, 85 and over, a smaller proportion of those women ever smoked in their life than might be the case with the modern woman? 15:08

A. I really don't have any data. 15:08

Q. You wouldn't know that either?

A. I wouldn't want to speculate on that. 15:08

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Q. What proportion of the women who are in nursing homes are there on account of smoking-related diseases? 15:08

A. I personally do not have any data to give me a number for that. 15:08

Q. What is your impression? You must have some impression about that. 15:08

A. Actually, I really can't -- I couldn't tell you. 15:09

Q. What are the disease entities that are -- are generally observed in the elderly female nursing home population? Osteoporosis? 15:09

A. Osteoporosis, which is related to smoking. Again, I don't know the population -- the distribution of diseases in the typical nursing home. I could not give you an intelligent answer on that, or a database. 15:09

Q. Who reports that osteoporosis is related to smoking? 15:09

A. There is data to show that osteoporosis is related to smoking. Actually, at the Texas Department of Health we have produced some information to that effect, yes. 15:09

Q. Have you examined that data to see whether it's confounded or whether it seems to be 15:10

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clean data and reliable? For example, you would grant, would you not, that smokers tend to be less active, that is more sedentary than nonsmokers?

A. I really can't give -- I'm not prepared to --

Q. You would grant, would you not, that a sedentary person is more likely to develop osteoporosis than a nonsedentary person.

A. First of all, I mean, I didn't agree with your first statement. I didn't comment on that. I think with osteoporosis, certainly increased physical activity is one of the things also that can help prevent osteoporosis, but again --

Q. The Exhibit Number 8 by Commissioner Sharp also -- Comptroller Sharp also says that the Texas -- the Texas-Mexico border area is home to a disproportionate share of the state's Medicaid-eligible population. Do you agree with that?

A. I really can't tell you.

Q. Did you know, sir, or do you know anything to the effect that while the 16 counties along the border with Mexico have only nine percent of the state's population, they account for

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17 percent of the state's Medicaid enrollees? 15:11
A. I'm not aware of that fact. 15:11
Q. Don't you, sir, sitting in your office here in Austin learn anything about the nature of the population out there across the state? 15:11
A. We certainly -- I would say that we look at the demographics. I'm talking about specific -- in terms of specific demographics of Medicaid recipients, I really can't give you an answer on that. 15:11
Q. Exhibit Number 9 that is entitled "Demographic Factors Affecting Texas" is put out by the Senate Research Center. Do you know of that group, do you? 15:12
A. The Senate Research Center? 15:12
Q. Yes. 15:12
A. Is that the Texas State Senate? 15:12
Q. Yes. 15:12
A. I'm not familiar with that group. I know the Texas Senate. 15:12
Q. Does your agency or your department contribute any data to the Senate Research Center? 15:12
A. I don't know. 15:12
Q. But now, you have been willing to rely upon 15:12

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other reports that you don't know much about, so let me ask you this. Do you agree that the Hispanic proportion of the Texas population is about 25.55 percent? 15:12 15:12 15:13 15:13

A. I've seen that figure from the census data. 15:13

Q. And that the -- where was that? Just a minute. And that the proportion of Hispanics in the Medicaid population is 45 percent of the total. 15:13 15:13 15:13 15:13

A. I don't know. 15:13

Q. Okay. Do you know what portion of the Medicaid population is comprised of African-Americans, the blacks? 15:14 15:14 15:14

A. The Medicaid or the state? 15:14

Q. Medicaid. 15:14

A. No, I don't. 15:14

Q. Does the number 24 percent look about right to you? 15:14 15:14

A. I don't know. 15:14

Q. Do you know how the number of -- of Texas Medicaid minority eligibles compares to the national Medicaid eligible minority population? 15:14 15:14 15:14 15:14

A. No, I don't. 15:14

Q. Does the figure of 11.66 percent for the 15:14

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state's African-American population as a whole without regard to Medicaid sound about right to you? 15:15

A. Yeah. I thought it was 11.9 or something, but okay, sure. That sounds reasonable. 15:15

Q. This document, "Demographic Factors Affecting Texas," asserts that -- it says, "Health problems along the Texas-Mexico border run the gamut from high rates of chronic diseases like heart disease and diabetes to communicable diseases like hepatitis and tuberculosis." Is that something that you would agree with? 15:15

A. Repeat that.

Q. "The health problems along the Texas-Mexico border run the gamut from high rates of chronic diseases like heart disease and diabetes to communicable diseases like hepatitis and tuberculosis." 15:15

A. That sounds reasonable. 15:15

Q. Actually, a disproportionate number or percentage of Hispanics suffer from diabetes, do they not? 15:16

A. Yes, they do. 15:16

Q. And can you give us some value on that of 15:16

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what the numbers are? 15:16
A. Off the top of my head, I can't give you a 15:16
good estimate. We have some figures on 15:16
that. It definitely is increased over the 15:16
Anglo. 15:16
Q. There is a significant difference, isn't 15:16
there?
A. Right. 15:16
Q. And it's also true, is it not, that a 15:16
disproportionate percentage of Hispanics 15:16
living in the unsanitary conditions of the 15:16
Rio Grande Valley, especially in the 15:16
Colonias, are prone to such things as 15:16
hepatitis and tuberculosis and other -- 15:16
dysentery, other communicable diseases? 15:16
A. It's not my area of expertise. 15:16
Q. But at any rate, dysentery, hepatitis 15:16
tuberculosis, diabetes has nothing to do with 15:17
smoking, does it? 15:17
A. In what sense? 15:17
Q. There's no causal relationship between those 15:17
diseases and cigarette smoking. 15:17
A. I mean, certainly there are some additive 15:17
effects. I mean, diabetics who smoke have 15:17
some increased complications. 15:17

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Q. Is it your judgment, or do you have a judgment either way that the Texas population as a whole is a suitable surrogate for the Medicaid population in Texas? 15:17
A. I really -- I mean, I can't -- 15:17
Q. You have no feeling about that either way? 15:17
A. What do you mean, surrogate? 15:17
Q. A good representation of the Medicaid population. 15:17
A. I really wouldn't speculate. 15:18
Q. If 15 percent of the Hispanic Texans smoke, as we talked about awhile ago, versus a substantially larger percentage of the population as a whole, you would expect less smoking-related diseases among the Hispanics, would you not? 15:18
A. Again, there is a breakdown between male and female Hispanics, and there is some data that -- you know, that the male Hispanics actually smoke higher than the state average. 15:18
Q. And where is that data? 15:18
A. I don't have it with me. I could get some data if you would like to see that. 15:18
Q. Well, if the overwhelming majority of the female -- of the Hispanic Medicaid population 15:18 15:19

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is female -- and that's true, isn't it? 15:19
A. Again, I don't know. 15:19
Q. Because of the way the Medicaid is structured. You've got single moms and you've got moms with little kids. Those are the Medicaid group, are they not? 15:19
A. Again, I do not claim to know the Medicaid population. That is not -- I have not reviewed that. 15:19
Q. I think you do reference in your list of references a thing called "Texas Medicaid in Perspective." Did you even look at that item? 15:19
A. I saw probably one chart showing the total Medicaid expenses, and I have not read that document, no. 15:19
Q. It reflects on Page 36, it's been identified here -- at least an excerpt from it has been identified as Exhibit Number 11. It reflects that 74 percent of all Medicaid recipients are either below 20 or above 65. Will you accept that since it says that in something that you've relied upon? 15:20
A. If it says that, sure. 15:20
Q. And that's the -- the groups over 65 and 15:20

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below 20 are the groups that are away from that peak smoking period that begins at age 25 and goes on up to age 45 or so; isn't that correct? So most of your smokers are going to be in the nonMedicaid group. 15:20

A. I guess I don't know what percentage is childbirth and perinatal and kids, and so, you know, in terms of impact, I really can't tell you. 15:20 15:21

Q. What part does teenage pregnancy play in perinatal problems such as low birth weight, respiratory distress syndrome, things such as that? 15:21

A. Say that again. 15:21

Q. What part does teenage childbearing play in the development of childhood problems or neonatal problems such as low birth weight, neuropathy, et cetera? 15:21

A. I can't really tell you. 15:21

Q. It plays a role, doesn't it? 15:21

A. I don't claim any expertise in that. I can't tell you. 15:21

Q. Isn't that part of the public health perspective? 15:21

A. There is a whole maternal and child health 15:21

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area of our department. 15:21
Q. And you have nothing to do with it? 15:21
A. We worked on some of the breast cancer 15:21
issues, but I have -- I'm not working on a 15:22
day-to-day basis with that. 15:22
Q. Do you recognize at least that the black 15:22
population tends to have a higher 15:22
percentage -- a significantly higher 15:22
percentage of low birth weight infants than 15:22
across-the-board population? 15:22
A. Say it again. 15:22
Q. Do you recognize that the -- that black 15:22
mothers as a population have a greater 15:22
percentage of low birth weight babies than 15:22
the population as a whole? 15:22
A. I have heard that statement made. 15:22
Q. Do you have any idea how many deaths from 15:22
heart disease have been caused by physical 15:22
inactivity? 15:22
A. In Texas? 15:22
Q. Yes. 15:22
A. I do not have a figure for that. 15:22
Q. Do you keep figures on that? 15:22
A. No, we do not. 15:22
Q. Do you keep figures on how many deaths from 15:22

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heart disease are caused by hypertension? 15:23
A. Say that again? How many -- 15:23
Q. How many deaths from heart disease are caused 15:23
by hypertension. 15:23
A. Not specifically in that manner. I mean, we 15:23
can look at some of the codes for 15:23
hypertension -- 15:23
Q. Have you developed --
A. -- and its cause. 15:23
Q. Have you developed a statistical system such 15:23
as SAMMEC to estimate the number of heart 15:23
disease deaths that are caused by physical 15:23
inactivity? 15:23
A. We have not developed such a thing. I know 15:23
McGinnis and Foge did an estimate nationally 15:23
about causes due to exercise and nutrition -- 15:23
Q. Has anybody developed a SAMMEC-like system 15:23
for estimating the number of heart disease or 15:23
cancer deaths, for that matter, caused by any 15:23
other risk factor other than smoking? 15:23
A. For heart disease? 15:24
Q. For heart disease or cancer or anything 15:24
else. 15:24
A. I'm not -- I'm not aware of anything. I've 15:24
seen -- I know that they were trying to do an 15:24

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alcohol model in the past. I haven't seen anything about that in the past several years, but I know that there was an alcohol program being developed at one point.

Q. Does your BRFSS data reveal that blacks and Hispanics have a higher than average rate of obesity and diabetes?

A. Yes. I would say we have a report where we've looked at obesity, and I can get you some of the figures on that if you'd like. I -- certainly with diabetes we know that there is increased diabetes among Hispanics.

Q. How about obesity?

A. Obesity -- can I take a look at that?

Q. It's in this stack somewhere?

A. Yes (indicating).

Q. Actually, if it's in this material, Doctor, we can find it ourselves.

A. Okay.

Q. Maybe if you can point it out to me, it will be faster, but the name of the item is called?

A. Well, "Weight and Nutrition" and -- hold on. "The Texas Risk Factor Report."

Q. Okay. If it's in that "Texas Risk Factor

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Report," we'll find it.
A. Okay. I mean, I can give you 37.2 percent of Hispanics and 33.2 of African-Americans were overweight, versus 23.8 percent of persons reporting white race were overweight.
Q. Okay. Does the number of 62 percent of Texas Medicaid eligibles being females, does that sound about right to you?
A. Again, I don't know.
Q. All right. If there's a difference in the demographics of the Texas Medicaid population, as opposed to the demographics of the Texas population as a whole, you would have a different set of risk factors brought to bear on those two populations, would you not?
A. Say that again?
Q. I say, if there were -- if there's a difference in the demographics of the Texas population as a whole and the Texas Medicaid population on the other hand, there would be a different risk profile as between those two populations, would there not?
A. I think just as we look at different subgroups, you know, I mean, I think we look

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at different racial -- you know, there's some different levels of risk factor prevalence among the races. I mean, I think that there are -- obviously different populations have some different risk factor prevalences. 15:27 15:27 15:27 15:27 15:27

Q. For example, there's no question but what the Medicaid population would tend to have a poorer dietary intake, would it not? 15:27 15:27 15:27

A. I can't say that. I don't know. I don't have anything to base that on. 15:28 15:28

Q. Do you recognize that the Medicaid population would tend to lead a more sedentary lifestyle? 15:28 15:28 15:28

A. Again, I have no -- enough information to make a statement like that. 15:28 15:28

Q. Do you collect information on areas that are especially impacted by toxic waste discharge? 15:28 15:28

A. What sort of information? 15:28

Q. Geographic areas that are especially impacted by toxic discharge. 15:28 15:28

A. In what manner? What are you saying? I mean, we collect information for the whole state. 15:28 15:28 15:28

Q. Right. Have you broken that down by area as to where there's more of it than others? 15:28 15:28

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A. More what? 15:28
Q. More toxic discharge than in the other areas. 15:28
A. I personally have not. There are other areas in the department that deal with cluster concerns and environmental toxic waste issues. I have not done that. 15:28
Q. Are there -- for example, are there cancer clusters that are in juxtaposition to or in the same locale of known toxic discharge sources? 15:29
A. I can't tell you specific ones. I know that the department conducts cancer cluster investigations based on public citizens' concerns, and frequently we see if there are excess cases of cancer in particular areas. 15:29
Q. Now, you told me awhile ago that you had an estimate of the prevalence of smoking in the adult Texas Medicaid population for the years '96 and '97, right -- or at least '96? 15:29
A. We have a figure from '96 data for the Medicaid -- those that reported being on Medicaid and being current smokers. 15:30
Q. Right. That's the BRFSS stuff. 15:30
A. Yes. 15:30

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Q. Do you have any information on the prevalence of smoking among the Texas Medicaid population for any years prior to '96? 15:30
A. No. 15:30
Q. Have you had any contact with Leonard Miller in your work on this case? 15:30
A. Early on I had -- what was it? I have met Leonard Miller, yes. 15:30
Q. And when was that? 15:30
A. I can't even remember. 15:30
Q. During this calendar year or last calendar year? 15:30
A. It was probably maybe sometime in 1995 or '96. 15:30
Q. Have you all talked about any aspect of your work on this case? 15:31
A. What do you mean by my work or -- 15:31
Q. Your work as an expert witness on this case. 15:31
A. No. 15:31
Q. Have you looked at anything that he's either published or prepared informally in your preparations for serving as an expert witness on this case? 15:31
A. Not really in preparation for serving as an expert witness on this case. I mean, I again 15:31

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glanced at something and did not really look at it.
Q. Can you recall what that might have been?
A. Now, are you talking about Leonard Miller?
Q. Yeah.
A. Actually, I can definitively say, for Leonard Miller, no.
Q. How about Vince Miller?
A. Again, I think it was I glanced at something from Vince Miller, but I did not really read it.
MR. HLAVINKA: Do you need a break?
THE WITNESS: Actually, could I get a break?
THE VIDEOGRAPHER: Going off the record at 3:31 p.m.
(RECESS)
THE VIDEOGRAPHER: We're back on the record at 3:44 p.m.
Q. Doctor, has your work in assessing the smoking population gone to the extent that you have come to recognize that there are differences between smokers and nonsmokers other than their smoking? For example, I

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mean, you said earlier that the less well-educated people are generally heavier smokers, right? 15:45

A. Right. I mean, that's some of the breakdowns that we've looked at. 15:45

Q. What other breakdowns have you identified? 15:45

A. Again, I mean -- let's see. It's actually -- no, I would say -- go back on that. It's not smokers versus nonsmokers. Some of the characteristics of the smoking population, again, that there are a higher percentage of -- I mean, in terms of the average income tends to be -- there are higher smoking rates among persons of lower income than of higher income. 15:45

Q. And how about lower educational level or achievement versus higher? 15:45

A. Right. Less than high school education -- persons with less than high school education have higher smoking rates than persons with -- did I say that right? 15:46

Q. Yeah. 15:46

A. Persons with lower education, less than high school education. 15:46

Q. All right. And these are the kinds of things 15:46

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that you look at from a public health standpoint as being things worth observing and drawing conclusions from, do you not? 15:46

A. We look at these and again evaluate the data and use it for planning and assessment. 15:46

Q. Have you satisfied yourself that -- from BRFSS studies or otherwise that smokers tend to use -- tend to use seat belts less than nonsmokers? 15:46

A. There is -- let me see in that report again. We did note that acute and chronic drinking, drinking and driving, lack of health care coverage, inability to see health care provider were significantly higher in smokers than in nonsmokers. 15:46 15:47

Q. The inability to see health care providers? 15:47

A. I believe that was -- let's see. 25 percent of smokers report that they were unable to see a doctor in the past year when they needed to due to cost, compared with 10 percent of -- 10.2 percent of nonsmokers. 15:47

Q. So those were the poor, right? 15:47

A. Well -- 15:47

Q. So smokers tend to be more poor? 15:47

A. That was their response to a particular 15:47

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question. Again, we have the data on income. 15:47
Q. But if their inability to see the doctor was 15:48
because of cost as the question was couched, 15:48
that means that they're poor folks, right, as 15:48
compared to the ones who have no problem with 15:48
the cost? 15:48
A. Well, again, the question stated the way it 15:48
is and --
Q. Have you ever seen data to the effect that 15:48
smokers tend to have a greater aversion for 15:48
health care than -- or at least a greater 15:48
aversion for regular health checkups and 15:48
things like that than nonsmokers have? 15:48
A. I have seen some data looking at tobacco use 15:48
and their -- how many visits. I can't recall 15:48
the specifics of that. 15:48
Q. They don't want to hear -- hear the sermon 15:48
about don't smoke, right, or whatever? 15:48
A. I don't know why. 15:48
Q. Have you seen data, or collected data for 15:49
that matter, that shows you that smokers are 15:49
greater risk takers across the board or as a 15:49
percentage or that there's a tendency for 15:49
smokers to be greater risk takers than 15:49
nonsmokers? 15:49

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A. Again, our data, we looked at drinking and driving risk, for instance, and, you know, 12.6 percent of smokers had a drinking and driving risk versus 5.2 percent of nonsmokers. 15:49

Q. That's one indication of risk taking, is it not? 15:49

A. It could be -- again, it reflects drinking and driving. 15:49

Q. So in many health-related respects, and you've mentioned some here today, there's a difference between the smoking population as a population and the nonsmoking population as a population; isn't that correct? 15:49 15:50

A. I would say that, again, we've talked about some characteristics that in terms of the income level have higher percentages of smokers than the low income and things like that. 15:50

Q. And the lower income people, then, who -- again, who would tend to be smokers, would tend to have poorer diets, would they not? They would tend to have, as you said, poor access to health care, other things that impact on one's health condition? 15:50

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A. I can't say that -- no, I can't say that the lower people who smoke have any particular risk factors versus the low income ones that don't smoke. No, I can't -- I can't say that. 15:50

Q. I understand, but there is a -- there is a -- if you take a smoker -- strike that. 15:51

If you take a population that's a nonsmoking population and a smoking -- and a population that's a smoking population, which you said awhile ago and correct me if I'm wrong, is that there are more poor folks in the second population than the first population, right? 15:51

A. I would not define poor. What I said was their income was less, that -- that comparing to those with greater than $35,000 income had lower smoking rates than some of those with a lower income. 15:51

Q. Have you made an effort at any point in your career to assess or to read about the relationship or correlation between income levels and overall health condition? 15:51

A. Say that again? 15:52

Q. Have you made any study, have you learned 15:52

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anything in all of your time about the correlation between overall health on the one hand and one's economic status on the other hand? 15:52

A. I would say that I have certainly seen -- I mean, socio-economic status is a factor in health, but that's a different question than whether some of the information links tobacco and that population. 15:52

Q. They might overlap, Doctor, might they not? 15:52

A. Pardon me? 15:52

Q. They might overlap some, might they not?

A. Again, what I would say, you know, I mean, I think that it's recognized socio-economic status brings a whole factor of health issues that people deal with. 15:53

Q. Have you in your experience here in Texas observed changes in the demographics, the racial and ethnic mix of our population over the years? 15:53

A. I'm not an expert. I'm not a demographer. I know that some of the figures say that by the year 2025 or something, you know, there is certainly going to be an increase in Hispanics, perhaps even over 50 percent of 15:53

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the population. Don't quote me. I know that there are these trends that are talked about -- 15:53

Q. And these trends have been in --

A. -- but again, I'm not an expert demographer. 15:53

Q. These trends have been in motion, though, for some time, have they not? They continue, but they have been in motion for some time? 15:53

A. I couldn't tell you how long any of these trends have been going on. 15:54

Q. All right. Do you know of any trends in the demographics of the Medicaid population? 15:54

A. No, I don't. 15:54

Q. Have you observed over the years -- and you've been in medicine either as a student or as a practitioner or in public health for more than 20 years now, right, or about 20 years? 15:54

A. I don't think so. 15:54

Q. Since '78? 15:54

A. No, not in medicine. That was, I mean, since '82 going -- starting medical school. 15:54

Q. All right. I thought I saw on your ring that you finished in '78. 15:54

A. That's Rice. That's my Rice ring. 15:54

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Q. What did you do between Rice and medical school? 15:54
A. That's 1982. 15:54
Q. It was upside down. It looked like '78 to me. So you've been 15 years. In that time have you seen changes in the percentage of health care costs that are devoted to hospitalizations versus the overall health care costs? 15:54 15:54 15:54 15:55 15:55 15:55
A. I couldn't really address that. 15:55
Q. You haven't seen those changes? 15:55
A. I have heard some trends. I can't really tell you, you know, specific. 15:55 15:55
Q. That's not within the scope of your work at the agency? 15:55 15:55
A. No, I'm not. That is not -- I would not say that that's something I deal with on a day-to-day basis. 15:55 15:55 15:55
MR. HLAVINKA: That's all I have. Thanks a lot. 15:55 15:55
THE VIDEOGRAPHER: Okay. We're going off the record at 3:55. 15:55 15:55
MR. THOMPSON: Let me just say, just for the record, that we have agreed to provide an additional date so that defendants 15:55 15:55 15:55

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will continue the deposition, and I will do so as I promised. 15:55

MR. HLAVINKA: I'll be in tomorrow and can hear from you. And this can be off the record as well. 15:55

THE VIDEOGRAPHER: We're off the record at 3:55 p.m. This is the end of Tape 3. 15:55

(DEPOSITION ADJOURNED)

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CHANGES TO DEPOSITION

No erasures or obliterations of any kind are to be made to the original testimony as transcribed by the deposition officer. Any changes in form or substance which the witness desires to make shall be furnished to the deposition officer by the witness, together with a statement of the reasons given by the witness for making such changes.

Please enter the page number, line number, and the reason for such change or correction.

Page/Line	Correction	Reason for Correction

_____
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WITNESS' SIGNATURE

STATE OF _____)
)
COUNTY OF _____)

I HEREBY CERTIFY that I have read the foregoing deposition and that this deposition, together with my corrections, is a true record of my testimony given at this deposition.

_____
PHILIP HUANG, M.D.

SUBSCRIBED AND SWORN TO BEFORE ME this the _____ day of _____, 19____.

_____
Notary Public in and for
State of _____

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REPORTER'S CERTIFICATE

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TEXARKANA DIVISION

THE STATE OF TEXAS, Plaintiff VS. THE AMERICAN TOBACCO COMPANY; R.J. REYNOLDS TOBACCO COMPANY; BROWN & WILLIAMSON TOBACCO CORPORATION; B.A.T. INDUSTRIES, P.L.C.; PHILIP MORRIS, INC.; LIGGETT GROUP, INC.; LORILLARD TOBACCO COMPANY, INC.; UNITED STATES TOBACCO COMPANY; HILL & KNOWLTON, INC.; THE COUNCIL FOR TOBACCO RESEARCH-USA, INC. (Successor to Tobacco Institute Research Committee); AND THE TOBACCO INSTITUTE, INC., Defendants	)	CIVIL ACTION NO. 5-96CV91

* *

PHILIP HUANG, M.D.

* *

I, SALLY KING, Certified Court Reporter for the State of Texas, do hereby certify that the facts stated by me in the caption hereof are true; that the said witness did make the above and foregoing answers in response to questions propounded as shown; that I did, in shorthand,

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report said proceedings, and that the above and foregoing typewritten pages contain a full, true and correct computer-aided transcription of my shorthand notes taken on said occasion.

I further certify that I am not in any capacity a regular employee of the party in whose behalf this deposition is taken, nor in the regular employ of any attorney of record; and I certify that I am not interested in the cause, nor a kin or counsel to either of the parties.

WITNESS MY HAND this the 15th day of September, 1997.

Sally King

SALLY KING, CSR
Certified Court Reporter
For the State of Texas
CSR No. 2299
Expiration Date: 12-31-97

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400 West 15th Street, Suite 604
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